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specialist in orthodontics

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PATIENT INFORMATION

Date: _____

Name: _____ Nickname: _____ Age: _____ Date of birth: _____ Sex: M F

Address: _____City: _____ Zip: _____ Phone: _____

E-mail address: _____ Whom may we thank for referring you to our office? _____

Do you have any friends or family with our office? _____

What is your chief concern for us at this visit? _____

What is your dentist's name? _____ City: _____

Patient's hobbies and interests: _____

If the patient is a **minor** please complete the following:

School: _____ Grade: _____

Responsible Party: _____ Relationship: _____ S.S. #: _____

Home Phone: _____ Address: _____ City; _____ Zip: _____

Work Phone: _____ Employer: _____ Occupation: _____

Father: _____ Employer: _____

Occupation _____ Work Phone_____

Mother: _____ Employer: _____

Occupation: _____ Work Phone: _____

If the patient is an **adult** please complete the following: Employer: _____

Occupation: _____ Work Phone: _____

Spouse: _____ Employer: _____

Occupation: _____ Work Phone: _____

ORTHODONTIC INSURANCE INFORMATION (Complete if you have orthodontic coverage)

Insured's Name: _____ Date of birth: _____ S.S. #: _____

Employer: _____

Insurance Co: _____ Group Number: _____ Local #: _____

Insured's Name: _____ Date of birth: _____ S.S. #: _____

Employer: _____

Insurance Co: _____ Group Number: _____ Local #: _____

ORTHODONTIC INFORMATION

1. Ever visit another orthodontist? Yes No If yes, results of visit: _____
2. Orthodontic appliances ever worn (when and how long)? _____
3. Are you aware that patient cooperation is the main factor in length of orthodontic treatment and quality of result? _____
4. Attitude toward orthodontic treatment: Eager _____ Neutral: _____ Negative: _____
5. If the patient is a minor: child's attitude toward personal responsibilities (i.e. homework, chores, etc.)
   Excellent _____ Average _____ Uncertain _____
6. Heights: Patient: _____ Mother: _____ Father: _____
7. Main reason for seeking information: _____
8. Major concern regarding treatment: _____

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EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____

Phone number(s) _____ _____ _____

HEALTH INFORMATION

Do you have any allergies we should know about before starting the exam (latex or other)? _____

Any medical conditions present? _____

Are you seeking treatment to reduce pain or discomfort? _____

X-rays are often required to give an accurate assessment of your or your child's bite problems. Do you consent to having x-rays taken today?

Please circle Yes No Signature: _____ Date: _____

MEDICAL HISTORY

Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

Medical History

Y N Are you in excellent health?
Y N Has there been any change in your general health within the last year?
Y N My last physical exam was _____ (month/year)
Y N Are you now under the care of a physician? If so, what is being treated? _____
Y N Have you had a serious illness/hospitalization in the past 5 years?
If so, for what? _____
Y N Are you taking any medication (including non-prescription)? _____

Do you have any of the following conditions?

Allergies or drug reactions to:
Y N Latex
Y N Penicillin or other antibiotics
Y N Sulfa drugs
Y N Local anesthetics
Y N Aspirin, Ibuprofen, Tylenol
Y N Codeine or other narcotics
Y N Other _____

Y N Respiratory problems, emphysema
Y N Asthma
Y N Hay fever
Y N Sinus trouble
Y N Persistent swollen neck glands
Y N Thyroid or endocrine problems
Y N Diabetes
Y N Hepatitis, jaundice or liver disease
Y N AIDS or HIV infection
Y N Substance abuse problem (past or present)
Y N Mental health problem or nervous disorder
Y N Fainting spells or seizures
Y N Abnormal weight and/or height for age
Y N Blood disorder such as anemia

Y N Abnormal bleeding or blood transfusion
Y N Low blood pressure
Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis)
Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease
Y N Arthritis, joint problems or artificial joints/limbs
Y N Require pre-medication before dental visits
Y N Birth defects
Y N Kidney trouble
Y N Tuberculosis
Y N Bone fractures or trauma to face or jaw
Y N Vision, hearing or speech difficulty
Y N Persistent cough
Y N Frequent colds or sore throats
Y N Frequent headaches
Y N Stomach ulcer or hyperacidity
Y N Tumor (cancerous or benign)
Y N Sexually transmitted disease
Y N Radiation therapy or chemotherapy
Y N Tonsils or adenoids removed? Same time? _____ What age? _____
Y N Epilepsy or other neurological disease
Y N Females: Menstruation started? Yes No If yes, what age? _____
Y N Females: Are you pregnant?

Y N Do you have any disease, condition or problem not listed above that you think we should know about?
If so, please explain _____

_____

DENTAL HISTORY

Name of patient's dentist _____ Date of last exam _____

Y	N	Chipped or injured permanent teeth	Y	N	History of extra or missing teeth?
Y	N	Teeth sensitive to hot or cold	Y	N	Have any permanent teeth been removed?
Y	N	Jaw fractures, cyst, mouth infections	Y	N	Have wisdom teeth been removed?
Y	N	Previous root canal therapy	Y	N	Teeth that irritate tongue, cheek, lip, etc.
Y	N	Bleeding gums or bad taste/mouth odor	Y	N	Previous orthodontic treatment or retainer
Y	N	Other periodontal (gum) problems	Y	N	Previous periodontal (gum) treatment
Y	N	Problems with food trapped between teeth	Y	N	Numerous fillings
Y	N	Frequent canker sores or cold sores	Y	N	Damaged restorations or fillings
Y	N	Mouth breathing habit or snoring troubles	Y	N	Thumb or finger habit as a child
Y	N	Abnormal swallowing (tongue thrust)	Y	N	Loose or shifting teeth
Y	N	Have you had a negative dental experience?	Y	N	Is all dental work completed at this time?
Y	N	Would you consider your diet high in sweets?			

Patient's deciduous ("baby") teeth came in ❑ Early ❑ Average ❑ Late
Patient's deciduous ("baby") teeth were lost ❑ Early ❑ Average ❑ Late
Patient's mouth most resembles ❑ Mother ❑ Father ❑ Neither

Has another family member received orthodontic care? Y N What? _____

TMJ HISTORY

Y	N	Have you had a TMJ screening?	Y	N	Do you experience pain in the muscles of your face or around your ears?
Y	N	Do you have a history of jaw joint problems	Y	N	Do you notice clicking or popping in your jaw joint?
Y	N	Have you been treated for "TMJ"?	Y	N	Do you have difficulty chewing or opening your mouth?
Y	N	Do you grind your teeth?	Y	N	Do you clench your teeth?
Y	N	Has our jaw ever locked?	Y	N	Does your bite feel uncomfortable or unusual?
Y	N	Do you have pain in your jaw joint?			

**I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any future changes to this history record or medical or dental status, I will inform the practice.

_____ _____
Signature Date Parent's signature if under 18 Date

_____ _____
Update signature Date Update signature Date

_____ _____
Update signature Date Update signature Date