PATIENT INFORMATION

Last Name_______________________First________________ Middle___________
Date of Birth________________ Age_____yrs_____months Sex M F
Address____
City________________________State ____Zip Code_______
Home Phone: ______________________ Cell Phone: _______________________
E-mail address: ____

Marital status: à Married à Divorced à Single à Widowed

Occupation:____
Employer:____
Address:____
City_______________________State ____Zip Code_________ Telephone ______________

Do you have insurance, which covers orthodontic treatment? à Yes à No
Primary Insurance_____________________ Policy no.________________
Address____
City________________________State ____Zip Code_______Telephone________________
Primary Insurance Holder's Date of Birth _______________Soc. Sec. No.______________

How did you hear about our office____

Children: Name __________________________Birthdate __________
Name _____________ Birthdate ___________ Name _____________ Birthdate ___________

Favorite Sports, Hobbies, Interests, and Musical Instrument Played___________________
____

(Please complete the medical and dental history on the reverse of this page.)

For the following questions please check **yes, no, or don't know (?)**. The answers are for office records only and will be considered confidential. A thorough and complete history is important to a proper orthodontic evaluation.

MEDICAL HISTORY

HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING:

	Yes	No	?		Yes	No	?
Heart Trouble	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Diabetes	☐	☐	☐	Tuberculosis	☐	☐	☐
Asthma	☐	☐	☐	Nervousness	☐	☐	☐
Epilepsy	☐	☐	☐	Fainting / Dizziness	☐	☐	☐
Seizures	☐	☐	☐	Prolonged Bleeding	☐	☐	☐
Aids / HIV	☐	☐	☐	Bone Disorders	☐	☐	☐
Cancer	☐	☐	☐	Liver Problems	☐	☐	☐
Anemia	☐	☐	☐	Kidney Problems	☐	☐	☐
Pneumonia	☐	☐	☐	Endocrine / Thyroid Disorder	☐	☐	☐

If yes to any of the above, explain: ____

	Yes	No	?
Are you in good health? ____	☐	☐	☐
Do you have any history of major illness? ____________________________	☐	☐	☐
Do you wear contact lenses? ______________________________________	☐	☐	☐
Have your tonsils or adenoids been removed? ___________________________	☐	☐	☐
Do you have rheumatoid or arthritic conditions? _________________________	☐	☐	☐
Do you have any learning disabilities or need extra help with instructions? __________	☐	☐	☐
List any drugs or medications you are now taking? ________________________	☐	☐	☐
List any drug sensitivity or allergies. ____________________________________	☐	☐	☐

DENTAL HISTORY

When did you last visit your dentist? ________________________ Last teeth cleaning?____________________
Name of Dentist:____

	Yes	No	?
Have you been informed of any missing or extra teeth? ___________________________	☐	☐	☐
Have you had any teeth removed? ____	☐	☐	☐
Has there been any injury to your face, mouth, or teeth? __________________________	☐	☐	☐
Have you had any problems with your speech? _________________________________	☐	☐	☐
Do you breath primarily through your mouth? _________________________________	☐	☐	☐
Have you had any clicking or discomfort in your jaw joints near your ears? __________	☐	☐	☐
Do you clench or grind your teeth? ____	☐	☐	☐
Are you aware of any gum problems, bleeding gums or bad odor? __________________	☐	☐	☐
Are you concerned about an over or under developed jaw? ________________________	☐	☐	☐
Have you had any previous orthodontic evaluations or treatment? __________________	☐	☐	☐
Do you feel you need orthodontic treatment? ____________________________________	☐	☐	☐
Are you apprehensive about orthodontic treatment? ______________________________	☐	☐	☐

What is your primary reason for this orthodontic evaluation? ____
____

I have read and understand the above questions and the answers are true to the best of my knowledge.

Signed ____ Date ___________________