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PATIENT INFORMATION

Patient's Last Name_____First_____ Middle_____
Patient's Date of Birth_____ Age_____yrs_____months Sex M F
Patient's Address_____
City_____State ____Zip Code_____Telephone_____

Parent / Person responsible for account _____
Address of responsible party_____
City_____State ____Zip Code_____ Telephone _____
E-mail Address_____
Parents are: □ Married □ Divorced □ Single Parent □ Widowed

Do you have insurance that covers orthodontic treatment? □ Yes □ No
Dental Insurance Co. Name_____ Policy no._____
Address_____
City_____State ____Zip Code_____Telephone_____
Primary Insurance Holder's Date of Birth _____SS# / ID#_____

Father's Name_____ Occupation_____
Employed by_____ Address_____
City_____ State ____Zip_____ Business Phone_____
Cell Phone _____

Mother's Name_____ Occupation_____
Employed by_____ Address_____
City_____State____Zip_____Business Phone _____
Cell Phone _____

Name of Patient's Dentist_____
How did you hear about our office?_____
Patient's siblings: Name _____DOB_____ Name_____
DOB _____ Name _____DOB _____
Patient's Height _____ Patient's Weight _____
Father's Height _____ Mother's Height _____
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

HAS THE PATIENT 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? _____	☐	☐	☐
Has the patient reached puberty? _____	☐	☐	☐
Has there been significant growth in height or weight in the last 6 months? _____	☐	☐	☐
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?_____
At approximately what age did you start teething? _____

	Yes	No	?
Have you been informed of any missing or extra teeth? _____	☐	☐	☐
Has the dentist had to remove any baby teeth? _____	☐	☐	☐
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? _____	☐	☐	☐
Do you have thumb sucking or finger habit? _____	☐	☐	☐
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 _____