A B C

Patient Information

Date _____

Patient's Name _____ M / F
Last First Middle Preferred First Name Sex

Address _____
Street City State Zip

Home Phone ( ) _____ Birthdate _____ Age _____ Social Security # _____

Patient's Dentist _____ Phone # ( ) _____ Referred By _____

Patient's Physician _____ Phone # ( ) _____ Other family members in treatment _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone ( ) _____ Work Phone ( ) _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

E-Mail _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone ( ) _____

Dental Insurance Information

Policy Holders
Name _____ Birth date _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Employer _____ Ins. Co. Phone # ( ) _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name _____ Birth date _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____ Ins. Co. Phone # ( ) _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone ( ) _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment: ❑ Yes ❑ No

Specify: _____

PRESENT DRUGS OR MEDICATION: ❑ Yes ❑ No

Specify: _____

Has patient been under care of a physician during the past two years other than for routine examination? ❑ Yes ❑ No

Birth Defects ❑ Yes ❑ No

Specify: _____

The following conditions are of interest to the orthodontist.
Has the Patient ever had:

❑ Yes ❑ No Asthma	❑ Yes ❑ No Diabetes	❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Anemia	❑ Yes ❑ No Epilepsy	❑ Yes ❑ No Heart Disease
❑ Yes ❑ No Blood Disease	❑ Yes ❑ No Endocrine Problems	❑ Yes ❑ No Hearing Disorder
❑ Yes ❑ No Bone Disorders	❑ Yes ❑ No Emotional Problems	❑ Yes ❑ No Head or Face Injury
❑ Yes ❑ No AIDS	❑ Yes ❑ No HIV Infections	❑ Yes ❑ No Rheumatic Fever
Comments:		❑ Yes ❑ No Osteoporosis

Does the patient:

1. Have allergies to: Seasonal grasses _____ Food _____

   Drugs _____ Other _____
2. Snore When Sleeping? ❑ Yes ❑ No
3. Breathe through mouth? Seldom Sometimes Usually Comments_____
4. Have Frequent colds? ❑ Yes ❑ No
5. Have Frequent sore throat or tonsillitis? ❑ Yes ❑ No

Has patient received medical treatment from allergist or ear, nose and throat specialist?

❑ Yes ❑ No if Yes: When _____ By Whom _____

Tonsils removed _____ Adenoids removed _____

Have any teeth been injured due to accidents or blows to the mouth? ❑ Yes ❑ No

Has the patient received or been requested to receive speech correction? ❑ Yes ❑ No

Thumb sucking until age _____ Grinding of teeth _____ ❑ Yes ❑ No

Finger sucking until age _____ Tongue thrusting _____ ❑ Yes ❑ No

Lip-biting or sucking? ❑ Yes ❑ No Other habits ❑ Yes ❑ No

Has the patient had any unusual dental experiences? ❑ Yes ❑ No

Specify: _____

Has the patient had previous orthodontic consultation or treatment? ❑ Yes ❑ No

Date: _____ Dr. _____

Are there any other medical, dental or surgical problems not covered above? ❑ Yes ❑ No

Do you have pain in the face, neck or shoulders? ❑ Yes ❑ No

Do you have frequent headaches? ❑ Yes ❑ No

Do you have recurring tooth pain or sensitivity? ❑ Yes ❑ No

Do you have ringing, fullness or pain in your ears? ❑ Yes ❑ No

Do you have difficulty opening your mouth or does your jaw get "stuck" or "locked"? ❑ Yes ❑ No

Do your joints make noises upon opening or closure? ❑ Yes ❑ No

Do you have difficulty or pain with chewing, talking or yawning? ❑ Yes ❑ No

Do you grind or clench your teeth? ❑ Yes ❑ No

Do you have arthritis? ❑ Yes ❑ No

Have you had any previous treatment for your jaw joint (TMJ problem)? If so, when and by whom? _____

FEMALES:

1. Age of menarche (first menstrual cycle)? _____
2. Do you take osteo-porosis medication? ❑ Yes ❑ No
3. Are you pregnant? ❑ Yes ❑ No

Signature _____ Date _____

Relationship to patient _____

_____

-FOR COMPLETION BY THE DOCTOR-

Comments on patient interview concerning medical history:

_____

_____

_____

_____

_____

_____

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