PATIENT INFORMATION

Patient's Name: ______________________________
Last *First* *Middle*

Birth Date: ______________________________

School and Grade Level or Occupation: ______________________________

Interests: ______________________________

List Siblings, Spouse, or Children: ______________________________

Have you received previous orthodontic treatment? **YES** **NO**

If yes, provide name of Orthodontist: ______________________________

Patient's chief orthodontic concern: ______________________________

Is the patient self-conscious of his/her smile? **VERY** **MODERATE** **UNCONCERNED**

Attitude toward braces: **EAGER** **RESIGNED** **INDIFFERENT**

Whom may we thank for referring you to our office?

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RESPONSIBLE PARTY INFORMATION

Patient lives with? Circle all that apply:

MOTHER **FATHER** **STEP-PARENT** **GRANDPARENT** **OTHER:** ______________

Name: ______________________________
Last *First* *Middle*

Address if different from patient: ______________________________

Previous Address if less than 3 years: ______________________________
No. of Years

Employer: ______________ Occupation: ______________ No. of Years Employed: _______

Spouse's Name: ______________ Relationship to Patient: ______________

Spouse's Employer: ______________ Occupation: ______________ No. of Years Employed: _______

INSURANCE INFORMATION

Do you have dental insurance? **YES** **NO** Please bring your insurance card and photo ID to the appointment.

EMERGENCY INFORMATION

Name of nearest relative not living with you? ______________ Relationship: ______________

Complete address ______________________________
Street *City* *State* *Zip* *Telephone*

MEDICAL & DENTAL HISTORY

Please circle Yes or No if the patient has or had any of the following:

Active Tuberculosis	**yes**	**no**
Persistent cough greater than a 3 week duration	**yes**	**no**
Cough that produces blood	**yes**	**no**
Been exposed to anyone with tuberculosis	**yes**	**no**

Is the patient in good health?	**yes**	**no**	**Reason:**___________________
Any major or unusual illnesses?	**yes**	**no**	**Reason:**___________________
Currently under physician's care?	**yes**	**no**	**Reason:** ___________________
Currently taking medication?	**yes**	**no**	**Reason:**___________________

Allergies? Latex: yes no Aspirin: yes no Nickel: yes no Other: ____________________

Anemia	**Yes**	**No**	**Heart Disease or Murmur**	**Yes**	**No**	**Frequent Colds**	**Yes**	**No**
Blood Disease	**Yes**	**No**	**Tuberculosis**	**Yes**	**No**	**Tonsillitis**	**Yes**	**No**
Prolonged Bleeding	**Yes**	**No**	**Diabetes**	**Yes**	**No**	**Mononucleosis**	**Yes**	**No**
Hepatitis	**Yes**	**No**	**Endocrine Problems**	**Yes**	**No**	**Rheumatic Fever**	**Yes**	**No**
AIDS or HIV positive	**Yes**	**No**	**Bone Disorders**	**Yes**	**No**	**Herpes or STD**	**Yes**	**No**
Jaundice	**Yes**	**No**	**Epilepsy**	**Yes**	**No**	**Asthma**	**Yes**	**No**
Cancer/Chemotherapy	**Yes**	**No**	**Adenoids removed**	**Yes**	**No**	**Tonsils removed**	**Yes**	**No**
Radiation Treatment:			**Year removed :** ________			**Year removed:** __________		

Other:

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Please circle Yes or No for the following questions:

Has the patient had any severe head or face injuries?	**Yes**	**No**	**Explain** ______________________
Has the patient had a history of thumb sucking or finger sucking?	**Yes**	**No**	**Stopped?** ______________________
Does the patient play any musical (wind) instruments?	**Yes**	**No**	**Explain** ______________________

Clenching Teeth	**Yes**	**No**	**High Decay Rate**	**Yes**	**No**	**Jaw Joint Popping/Clicking**	**Yes**	**No**
Grinding Teeth	**Yes**	**No**	**Headaches (more than normal)**	**Yes**	**No**	**Ringing in the Ears**	**Yes**	**No**
Jaw Joint Soreness	**Yes**	**No**	**Tongue Thrust**	**Yes**	**No**	**Snoring Loudly**	**Yes**	**No**
Mouth Breather	**Yes**	**No**	**Muscular Soreness (neck & head area)**	**Yes**	**No**	**Speech Problems/ Speech Therapy**	**Yes**	**No**
Hard Blow to Chin	**Yes**	**No**						

Other:

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I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services as needed during diagnosis and treatment.

Signature: ____ **Date:** ____________________

Responsible Party Signature Line *Print Name*

Signature: ____ **Date:** ____________________

Dentist Signature

Comments

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