Date_____ **Confidential Patient Information** KUHNI ORTHODONTIC STUDIO A B C

Patient's Name _____ Birthdate_____ Age_____
(Last) (First) (M.I) (Preferred Name)

Interests/Hobbies _____ Patient's Cell Phone _____ ☐ Male ☐ Female

Patient's Physical Address _____
(Street) (City) (State) (Zip)

Patient's Other Address _____
(Street) (City) (State) (Zip)

Dentist _____ Last Cleaning _____Who may we thank for your referral?_____

List any immediate family members seen in our office _____

Responsible Party _____Marital Status _____
(Last) (First) (Middle)

Birthdate _____Employer _____ Occupation _____ Years Employed _____

Residence _____ ☐ Own ☐ Rent ☐ Other
(Street) (City) (State) (Zip)

How long at this address _____ Previous Address (if less than 3 years) _____

Email _____Cell # _____ SS # _____

Responsible Party's Spouse _____ ☐ Mother ☐ Father ☐ Step-Parent ☐ Other
(Last) (First) (Middle)

Birthdate _____ Employer _____ Occupation _____ Years Employed _____

Email _____ Cell # _____ SS # _____

Please list anyone else who may be bring the patient to their appointment: _____

_____

Please list individuals whom orthodontic treatment can be shared: _____

_____

Dental Insurance _____ Policy Holder _____ Birthdate _____

Insurance Company Address _____ Phone # _____

Policy ID (or SS#) _____ Group # _____ Employer_____

Secondary Insurance _____ Policy Holder _____ Birthdate _____

Insurance Company Address _____ Phone # _____

Policy ID (or SS#) _____ Group # _____ Employer_____

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

Custodial Parent Signature _____

Dental and Orthodontic History

What is the main orthodontic concern? _____

Have you had any previous orthodontic treatment or consultation? ☐ Yes ☐ No

If so, what was completed, and by whom? _____

What other family member(s) have had orthodontics? _____

Were they results acceptable? ☐ Yes ☐ No

Do you now have or have you experienced pain or discomfort in your jaw joint? ☐ Yes ☐ No

Do you grind your teeth? ☐ Yes ☐ No

Do you have any speech problems/tongue thrust? ☐ Yes ☐ No

Do you have or have you ever had any thumb or finger sucking habits? ☐ Yes ☐ No

Do you breath through you mouth while awake? ☐ Yes ☐ No

Have you ever experienced an adverse reaction during a medical or dental procedure? ☐ Yes ☐ No

Have you ever received serious trauma or injury to the teeth, face, jaws or head? ☐ Yes ☐ No

Do you have a family history of jaw size imbalance or missing, impacted, malformed or extra teeth? ☐ Yes ☐ No

Have you been treated for or diagnosed with any periodontal problems? ☐ Yes ☐ No

If yes to any of the above, please explain: _____

_____

Medical History

Please check if you have a history of any of the following:

Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Heart Disease or Conditions
☐	☐	Allergies (latex, codeine, penicillin, metals, anesthetics, other)	☐	☐	Heart Murmur
☐	☐	Artificial Joints or Valves	☐	☐	Headaches
☐	☐	Asthma or Hay Fever	☐	☐	Hepatitis
☐	☐	Blood Pressure Problems	☐	☐	Mitral Valve Prolapse
☐	☐	Cancer, Tumor, Radiation Treatment or Chemotherapy	☐	☐	Osteoporosis/Osteopenia
☐	☐	Convulsion, Epilepsy or Fainting Spells	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Diabetes	☐	☐	Rheumatoid or Arthritic Conditions
☐	☐	Difficulty Breathing	☐	☐	Tonsillitis
☐	☐	Endocrine, Thyroid or Growth Problems	☐	☐	Tuberculosis
☐	☐	Excessive bleeding, anemia or bleeding disorder			

If you answered ye to any of the above, please explain in more detail: _____

_____

Are you under the care of a physician for a specific condition not listed above? ☐ Yes ☐ No

If yes, please describe: _____

Are you taking any medications? (including bisphosphonates, anti-inflammatories and steroids) ☐ Yes ☐ No

If yes, please list medication and what it's taken for: _____

_____

Authorization

I have reviewed the information on this questionnaire and t is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. I also understand that if there is any change to my, or the above named patient's dental or medical status, it is my responsibility to inform the doctor.

Signature _____ Date: _____