

Date _____

Confidential Patient Information



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

Girls: Has menstruation started? Yes No If yes, what age? _____

Boys: Has voices changed? Yes No

Please best describe the patient's attitudes toward orthodontic treatment:

Wants treatment Treatment is necessary. Unwilling, but agrees. Uncooperative

Medical History

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

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