Patient Information and Health History

The following information is requested so that we may effectively evaluate your orthodontic condition and provide you with the appropriate recommendations regarding your overall health. All information provided is confidential. Please circle the appropriate response where indicated.

Patient's Name_____Age____ Birthdate_____ Gender____
Home Address_____
City and Zip Code_____ Home Phone_____
Email Address_____ Mobile Phone_____
Patient's Occupation or School Level _____ Business Phone_____
Person Responsible for Account_____ Home Phone_____
Relationship_____ Occupation_____ Employer_____
Is the Patient Covered by Insurance for Orthodontic Treatment? Yes No
If yes, by which company?_____
Name of Person to be contacted if the patient cannot be reached or in case of emergency:
Name_____ Relationship_____
Address_____ Phone_____
Family Dentist_____ Referred by_____
Primary Care Physician_____

Family Status

Siblings None ___ Number of brothers ___ Number of sisters
Father's Name_____ Living? Yes No
Mother's Name_____ Living? Yes No
Other family members with similar orthodontic condition
Father Mother Brother Sister Other (Specify)_____
Patient Living with _____

Medical and Dental History

Present Health Good Fair Poor Under Treatment? Yes No
Specify_____
Is patient taking any drugs or medications? Yes No
Specify_____
Any adverse reactions to medications or foods? Yes No
Specify_____
Has the patient been under care of a physician during the past two (2) years, other than for routine examination? Yes No
Specify
Any birth defects? Yes No
Specify_____
Has the patient reached puberty? Yes No
Has the patient ever had a blood transfusion or received blood by-products? Yes No

Does the patient have (or does the patient have a history of):

	Yes	No		Yes	No		Yes	No
Asthma.....	___	___	Diabetes.....	___	___	Hearing Disorder.....	___	___
Anemia.....	___	___	Epilepsy.....	___	___	Head/face injury.....	___	___
Blood disease or			Endocrine problems.....	___	___	Hepatitis.....	___	___
bleeding problems.....	___	___	Emotional problems.....	___	___	Rheumatic Fever.....	___	___
Bone disorders.....	___	___	Fainting Spells.....	___	___	Scarlet Fever.....	___	___
Breathing problems.....	___	___	Heart Condition.....	___	___	Tuberculosis.....	___	___
Other.....	___	___						

Comments:_____
_____

Does the Patient:

1. Have allergies to: Seasonal Grasses_____ Other_____
2. Snore when sleeping? Yes No
3. Breath through mouth? Seldom Sometimes Usually
   Comments:_____
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have difficulty chewing or swallowing? Yes No

Has the patient ever received medical treatment from an Allergist or ENT (Ear, Nose & Throat) specialist? Yes No

If yes: When_____ By Whom_____

Tonsils Removed_____ Adenoids Removed_____

Does the patient have pain or clicking in the jaw joints? Yes No

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

Has the patient received or been advised to receive speech therapy? Yes No

The following habits are of interest to the orthodontist:

Thumb sucking until age_____ Finger sucking until age_____ Grind of teeth Yes No

Tongue thrusting Yes No Lip biting or sucking Yes No

Other habits_____

Does the patient play a musical insturment? Yes No

Specify_____

Has the patient had any unusual dental experiences? Yes No

Specify_____

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

Specify_____

Are there any medical, dental, or sugical conditions not covered above? Yes No

Specify_____

Patient's attitude toward teeth, face, and orthodontic treatment:

Dental Check-ups: Twice a year Once a year Only if Urgent Never

Date of last check-up_____ Were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problems? Yes No

Patient's interest in orthodontic treatment:

Patient wants treatment ___Treatment if necessary ___ Unwilling ___Uncooperative

Orthodontic consultation prompted by: _ Patient __Dentist __Mother __Father __Spouse

__ Sibling __Physician __Friend __Other (Specify)_____

Why did you seek this evaluation?

_____
_____
_____

Signature_____ Date_____ Relationship to Patient_____

Orthodontic Insurance Information:

Patient Information

Name_____

Relationship to subscriber: ___Self ___Spouse ___Child ___Other

Gender: ___Male ___Female

Date of Birth_____

Subscriber/Employee Information

Name_____

Date of Birth_____

Social Security Number_____

Mailing address_____

_____

Company (employer that provides the insurance)_____

Insurance Company_____

Insurance Address _____

_____

Insurance Phone number_____

Member ID_____ Contract Number _____

Group Number_____

Secondary Insurance

Subscriber/Employee Information

Name_____

Date of Birth_____

Social Security Number_____

Mailing address_____

_____

Company (employer that provides the insurance)_____

Insurance Company_____

Insurance Address _____

_____

Insurance Phone number_____

Member ID_____ Contract Number _____

Group Number_____