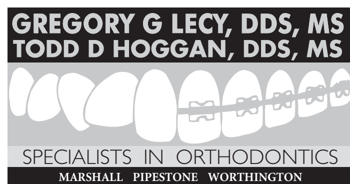

Date________________

Patient Information

Name: ______________________ Preferred Name: ______________ ❑ Male ❑ Female

Address: ______________________ City: ______________ State: ______ Zip Code: ________

Birth date: ______________________ Home Phone: ______________________

Dentist: ______________________ Physician: ______________________

If applicable, cell phone: ______________________ E-mail address: ______________________

Hobbies: ______________________ Patient's school: ______________________ Grade: ________

Custodial parents' or guardians' name/s: ______________________

Responsible Party Information

Father's name: ______________________ Birth date: ______________ Marital Status: ________

Address (if different from patient): ______________________ City: ______________ State: ______ Zip Code: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

E-mail address: ______________________ Best way to contact: ______________________

Occupation: ______________________ Employed by: ______________________

Mother's name: ______________________ Birth date: ______________ Marital Status: ________

Address (if different from patient): ______________________ City: ______________ State: ______ Zip Code: ________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

E-mail address: ______________________ Best way to contact: ______________________

Occupation: ______________________ Employed by: ______________________

Dental Insurance Information

Insured's name: ______________________ Birth date: ______________

Insured's ID# or SSN#: ______________________ Group #: ______________

Insurance Company: ______________________ Insurance Co. Phone #: ______________

Insurance Company Address: ______________________

Please bring your dental insurance card.

Signature on file: I understand that I am responsible for all costs of dental treatment.
I authorize the use of this form and its information for all my insurance submissions.
I authorize this office and its employees to act as my agent in helping me obtain reimbursement.
I authorize insurance payment directly to this office.
I authorize the use of a copy of this form which can be used in place of the original.

Signature: ______________________ Date: ______________

Has any family member received treatment at our office: ❑ Yes ❑ No If yes, who: ______________

Whom may we thank for referring you to our office? ______________________

Other than responsible party noted above, whom may we notify in case of an emergency? ______________

Relationship: ______________ Phone: ______________ Address: ______________

For the following questions circle yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No dk/u Does patient follow directions?
Yes No dk/u Does patient brush his/her teeth conscientiously?
Yes No dk/u Does patient have learning disabilities or need extra help with instructions.
Yes No dk/u Is patient sensitive, self-conscious?

MEDICAL HISTORY
Now or in the past, have you had:

Yes No dk/u Birth defects or hereditary problems?
Yes No dk/u Bone fractures, any major accidents?
Yes No dk/u Rheumatoid or arthritic conditions?
Yes No dk/u Endocrine or thyroid problems?
Yes No dk/u Kidney problems?
Yes No dk/u Diabetes?
Yes No dk/u Cancer or been treated for a tumor?
Yes No dk/u Stomach ulcer or hyperacidity?
Yes No dk/u Polio, mono, tuberculosis, pneumonia?
Yes No dk/u Problems of the immune system?
Yes No dk/u AIDS or HIV positive?
Yes No dk/u Hepatitis, Jaundice or liver problem?
Yes No dk/u Fainting spells, seizures, epilepsy or neurologic problems?
Yes No dk/u Mental health or behavioral problem?
Yes No dk/u Vision, hearing, tasting or speech difficulties?
Yes No dk/u Loss of weight recently, poor appetite?
Yes No dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
Yes No dk/u High or low blood pressure?
Yes No dk/u Tires easily?
Yes No dk/u Chest pain, shortness of breath or swelling ankles?
Yes No dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arterloscierosis, stroke, inborn heart defects or rheumatic heart disease)?
Yes No dk/u Skin disorder
Yes No dk/u Do you have a normal and good diet?
Yes No dk/u Frequent headaches, colds or sore throats?
Yes No dk/u Eye, ear, nose, throat condition?
Yes No dk/u Hayfever, asthma, sinus trouble, hives?
Yes No dk/u Tonsil or adenoid conditions?
Yes No dk/u Allergies or drug reactions?
Yes No dk/u Are you taking medication, nutrient supplements or non prescription medicine? Please name them.
Medication_______________________________________
taken for _______________________________________
Medication_______________________________________
taken for _______________________________________
Medication_______________________________________
taken for _______________________________________
Yes No dk/u Does the patient currently have or ever had a substance abuse problem?
Yes No dk/u Operations (surgical procedures)?
Yes No dk/u Hospitalized for___________________________________
Yes No dk/u Other physical problems or symptoms?
Yes No dk/u Being treated by another health care professional?
For____
Date of most recent physical exam?________________

DENTAL HISTORY

Yes No dk/u Started teething very early or late
Yes No dk/u Primary (baby) teeth removed that were not loose?
Yes No dk/u Permanent or "extra" (supernumerary) teeth removed?
Yes No dk/u Supernumerary (extra) or congenitally missing teeth?
Yes No dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
Yes No dk/u Teeth sensitive to hot or cold: teeth throb or ache?
Yes No dk/u Jaw fractures, cysts, mouth infections?
Yes No dk/u "Dead Teeth", root canals treated?
Yes No dk/u Bleeding gums, bad taste, mouth odor?
Yes No dk/u Periodontal "Gum Problems"?
Yes No dk/u Food impaction between teeth?
Yes No dk/u "Gum Boils", frequent canker sores, cold sores?
Yes No dk/u Is child taking any forms of fluoride?
Yes No dk/u Thumb, finger, sucking habit? Until ________________
Yes No dk/u Abnormal swallowing habit (tongue thrusting)?
Yes No dk/u History of speech problems?
Yes No dk/u Mouth breathing habit, snoring, difficulty in breathing?
Yes No dk/u Tooth grinding, jaw clenching, clicking, locking?
Yes No dk/u Any pain in jaw or ringing in the ears?
Yes No dk/u Does the patient experience any pain or soreness in the muscles of the face, or around the ears?
Yes No dk/u Difficulty encountered in chewing or jaw opening?
Yes No dk/u Aware of loose, broken or missing restorations (fillings)?
Yes No dk/u Any teeth irritating cheek, lip, tongue, palate?
Yes No dk/u Concerned about spaced, crooked, protruding teeth?
Yes No dk/u Aware or concerned about under or over developed jaw?
Yes No dk/u Any relative with similar tooth or jaw relationships?
Yes No dk/u Any wisdom tooth problems?
Yes No dk/u Has patient had any serious trouble associated with any previous dental treatment?
Yes No dk/u Onset of puberty (approximate date)? ______________
Yes No dk/u Has patient ever had a prior orthodontic examination or treatment?
Yes No dk/u Has patient recently been under another dentist's care?
Specialist ______________________________________
Other ____
Yes No dk/u Has patient ever had periodontal (gum) treatment?
Yes No dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Date most recent dental examination _____________________________
How often does patient brush ______________floss ______________
What is the patient's (or parent's) primary concern? - Why are you here?
____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps or problems that might be encountered during treatment?

____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

____
Signature (Parent's Signature if Minor) Date

Medical History Update or Changes: Date: Comments: Signature:

____
____
____
____
____
____