



Patient Health and Information

Date: _____

Patient's Name: _____

Sex: _____ DOB _____ Age: _____

Name they wish to be called: _____

Home Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Resides with: _____

Relationship to Patient: _____

Person responsible: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

SS#: _____

Insurance Carrier: _____ DOB _____

Name of Nearby Relative of Patient: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Please answer the following if patient is 18 years old or younger.

Father's Name: _____

SS#: _____

Employer: _____

Work Phone: _____

Mother's Name: _____

SS#: _____

Employer: _____

Work Phone: _____

Patient's School: _____

Hobbies: _____

Other Children in Family: Y / N Were they patients here? Y / N When: _____ Their Ages: _____

Do you realize most Orthodontic appointments are during school hours? _____

Does anyone in the family (other than patient) have any of the following?

Crowded teeth Spaced teeth Protruding teeth Other

Does the patient have any feelings about the appearance of His/Her Teeth? _____

Is the patient interested in having orthodontic appliances? Y / N

How did you hear about us? Dentist Referral _____ Insurance Company _____

Friend Referral: _____ Drive by Phone Book Other _____

Dental History:

Patient's Dentist: _____ Date of Last Check-Up: _____ Any X-rays: _____

Address: _____ City: _____ State: _____ Zip: _____

Chief complaint or reason for seeking orthodontics: _____

Do your teeth hurt? Y / N If yes, Upper Right Upper Left Lower Right Lower Left

Have you ever had treatment for a gum disease? Y / N Please Describe: _____

Have you ever had any previous orthodontic treatment or been examined by another Orthodontist? Y / N

Describe: _____ Dr. Name: _____ When _____



Any injuries to your mouth or teeth? Y / N Describe: _____
 Any injury to the head or neck area? Y / N Describe: _____
 Any surgery in the head or neck area? Y / N Describe: _____
 Do you clench or grind your teeth? Y / N If yes, when sleeping under stress other _____
 Do your jaw muscles ever feel tired? Y / N If yes, when: _____
 Does it hurt to chew? Y / N If yes, where does it hurt? _____
 Do you hear clicking (popping) or grinding sounds in your jaw joint? Y / N If yes, describe: _____
 Have your jaws ever "locked" open wide or closed? Y / N If yes, describe: _____
 Do you have pain in your jaw joint? Y / N If yes, describe: _____
 Did the patient have a thumb or finger habit? Y / N At what age did he/she quit? _____
 Please describe why you have sought this consultation: _____
 Have you ever been treated for this problem before: Y / N If yes, please describe the diagnosis and treatment: _____

Medical History:

Name of Physician: _____ Date of last check-up: _____
 Address: _____ City: _____ State: _____ Zip: _____

Have you ever or do you have any one of the following:

	Yes	No		Yes	No
Rheumatic Fever	_____	_____	Allergies (Drug & Other)	_____	_____
Heart Murmur	_____	_____	List: _____		
High Blood Pressure	_____	_____	Asthma	_____	_____
Heart Attack or Stroke	_____	_____	Arthritis (any type)	_____	_____
Blood Vessel Disease	_____	_____	Cancer	_____	_____
Persistent Headaches	_____	_____	Epilepsy	_____	_____
Neck Pains	_____	_____	Tonsillectomy	_____	_____
Nerve or Brain Disease	_____	_____	Head or Face Injury	_____	_____
Migraine	_____	_____	Psychological Problems	_____	_____
Cold Sores	_____	_____	Bleeding Problem	_____	_____
Diabetes	_____	_____	TB or Lung Problems	_____	_____
Hepatitis	_____	_____	Unintentional Weight Loss	_____	_____
Aids or HIV Positive	_____	_____	Current Illness: _____		
Sinus Infection	_____	_____	Recurrent Illnesses: _____		
Swollen Glands	_____	_____			

Comments: _____
 Please list any other significant information about your medical history: _____
 Are you currently under a physician's care? Y / N If yes, reason: _____
 What medications are you currently taking? _____

Signature: _____ Relationship to Patient: _____ Date: _____