



## patient information

Date \_\_\_\_\_ Email Address \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle Sex M/F

Address \_\_\_\_\_  
Street City Zip

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Dentist Phone \_\_\_\_\_

Who suggested that you might need orthodontic treatment? \_\_\_\_\_

Main reason for seeking orthodontic treatment \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

## responsible party information

Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_



### dental insurance information

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ ID \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ ID \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

### emergency information

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_

### fun facts for kids (and adults)

What would you like to see in your orthodontist? \_\_\_\_\_

Nickname \_\_\_\_\_ School and grade level \_\_\_\_\_

Favorite hobby \_\_\_\_\_ Favorite food \_\_\_\_\_

Favorite animal \_\_\_\_\_ Favorite person \_\_\_\_\_

Favorite sport \_\_\_\_\_ Favorite musical artist \_\_\_\_\_

Musical instruments played \_\_\_\_\_ Siblings? \_\_\_\_\_

Any other information you would like us to know: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---



medical history

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details). Parents/Guardians please respond for minors.

- Yes No Are you taking any medication/supplements/herbals? \_\_\_\_\_
- Yes No Are you allergic to any medication/foods/latex/metals/acrylics/anesthetics etc? \_\_\_\_\_
- Yes No Do you have a history of a major illness? \_\_\_\_\_
- Yes No Have you had any major operations? \_\_\_\_\_
- Yes No Have you ever been involved in a serious accident? \_\_\_\_\_
- Yes No Are you/have you taking/taken bisphosphonates for osteoporosis or other bone diseases? \_\_\_\_\_
- Yes No Do you chew or smoke tobacco products? If so, how long? \_\_\_\_\_
- Yes No Do you have or have you ever had a substance abuse problem? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

- Abnormal bleeding/Hemophilia Diabetes Herpes Prolonged Bleeding
- Anemia Dizziness High Blood Pressure Radiation / Chemotherapy
- Arthritis Epilepsy HIV / AIDS Rheumatic Fever
- Asthma or Hayfever Gastrointestinal Disorders Kidney problems Sleep Apnea
- Bone Disorders Heart Problems / Heart Murmur Nervous Disorders Tuberculosis
- Congenital Heart Defect Hepatitis / Liver problems Pneumonia Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

Does your physician recommend premedicating with antibiotics prior to dental procedues? \_\_\_\_\_

dental history

Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

- Yes No Are you happy with the appearance of your teeth? \_\_\_\_\_
- Yes No Are you presently in any dental pain? \_\_\_\_\_
- Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_



- Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_
- Yes No Do your gums bleed when you brush? \_\_\_\_\_
- Yes No Are you concerned about bad breath? \_\_\_\_\_
- Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Are you a mouth breather? \_\_\_\_\_
- Yes No Do you snore loudly? \_\_\_\_\_
- Yes No Do you often feel tired, fatigued, or sleepy throughout the day? \_\_\_\_\_
- Yes No Are you being treated for sleep apnea? \_\_\_\_\_
- Yes No Do you have/have you had a tonsil or adenoid conditions? \_\_\_\_\_
- Yes No Have you been told you have a tongue thrust? \_\_\_\_\_
- Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in your family received orthodontic treatment?  
How did they feel about the result? \_\_\_\_\_
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
- Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_
- Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_
- Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_
- Yes No Do you have "tension" headaches? \_\_\_\_\_
- Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_  
If the patient is under age 16, height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_
- Yes No Are there any familial medical conditions we should know about? \_\_\_\_\_

**Female Patients only:**

- Yes No Are you pregnant? \_\_\_\_\_
- Yes No Has menstruation started (This is useful in monitoring/modifying growth of head and jaw bones)? \_\_\_\_\_

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_