

Patient Information

Date: _____ Whom may we thank for referring you to our office? _____
Patient's Full Name: _____ Email: _____
Address: _____
Phone: _____ Date of Birth: _____ Social Security No: _____

Responsible Party Information

Full Name: _____ Email: _____
Address: _____
How long at this address? _____ Phone No: _____ Alternate Phone No: _____
Previous Address (If less than 3 years) _____
Spouse's Full Name: _____ Email: _____
Phone No: _____ Alternate Phone No: _____

Emergency Information

Name of nearest relative not living with you: _____ Phone No: _____
Address: _____

Medical History

Physician: _____ Date of last visit: _____ Phone No: _____
Address: _____

Yes No Are you taking any medication? _____ Yes No Are you allergic to any medication? _____
Yes No Do you have a history of any major illnesses? _____ Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____

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

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

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

Dental History

Dentist: _____ Date of last visit: _____

What concerns you most about your teeth? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____ Yes No Are you a mouth breather? _____
Yes No Have you ever lost or chipped any adult 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 Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
Yes No Do your gums bleed when you brush? _____ Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in you family received orthodontic treatment? _____ Yes No 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 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 Are you aware that some appointments will be during the school/work hours? _____

Please list some hobbies/interests: _____

Female patients only: Yes No Are you pregnant? _____ Yes No Has menstruation started? _____

Benefits

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): _____ Date: _____

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth changed throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature: _____ Date: _____