Patient

Patient's last name: _____ First name: _____ Middle initial: _____

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. I prefer to be called: _____

Birthday: _____ ☐ Male ☐ Female

Home Address: _____ City, State, Zip code: _____

Home phone: _____ Cell phone: _____ Work phone: _____

E-mail: _____

Occupation: _____ Employer: _____ Present position: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If remarried, spouse name: _____

Occupation: _____ Employer: _____ Present position: _____

Who is financially responsible for this account? _____

Whom can we thank for this referral? ☐ Dentist: *(name)* _____

☐ Friends or Family: *(name)* _____ ☐ Friends or Family: *(name)* _____

☐ Family members who have been patients: *(name & relationship)* _____

Dentist + Physician

Patient's Dentist: _____ City, State: _____

Last seen: _____ Reason: _____

Other dentists/dental specialists now being seen: Name: _____ City, State: _____

Reason: _____

Patient's Physician: _____ City, State: _____

Last seen: _____ Reason: _____ Next appointment: _____

Most recent physical exam: _____

Dental Insurance

Primary policy holder's full name: _____ Birth date: _____

Social Security#: _____ Relationship to patient: _____

Address: *(if different than above)* _____

Employer: _____ Address: _____

Insurance company: _____ Group#: _____ ID#: _____

Does this policy have orthodontic benefits?: ☐ Yes ☐ No ☐ Don't Know

Secondary policy holder's full name: _____ Birth date: _____

Social Security#: _____ Relationship to patient: _____

Address: *(if different than above)* _____

Employer: _____ Address: _____

Insurance company: _____ Group#: _____ ID#: _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

Medical History | *Now or in the past, have you had:*

Please Check YES	NO		Please Check YES	NO	
☐	☐	Birth defects or hereditary problems?	☐	☐	Vision, hearing, or speech problems?
☐	☐	Bone fractures or major injuries?	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	Any injuries to face, head, neck?	☐	☐	High or low blood pressure?
☐	☐	Arthritis or joint problems?	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	Endocrine or thyroid problems?	☐	☐	Chest pain, shortness of breath, tire easily, swollen ankles?
☐	☐	Diabetes or low sugar?	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	Kidney problems?	☐	☐	Angina, arteriosclerosis, stroke or heart attack?
☐	☐	Cancer, tumor, radiation treatment or chemotherapy?	☐	☐	Skin disorder (other than common acne)?
☐	☐	Stomach ulcer, hyperacidity, acid reflux?	☐	☐	Do you eat a well-balanced diet?
☐	☐	Immune system problems?	☐	☐	Frequent headaches or migraines?
☐	☐	History of osteoporosis?	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	AIDS or HIV positive?	☐	☐	Asthma, sinus problems, hayfever?
☐	☐	Hepatitis, jaundice, or other liver problems?	☐	☐	Tonsil or adenoid condition?
☐	☐	Seizures, fainting spells, neurologic problems?	☐	☐	Do you frequently breathe through your mouth?
☐	☐	Mental health disturbance or depression?	☐	☐	Allergies to drugs or latex?

If you have checked Yes for any of the above, please explain: _____

Dental History | *Now or in the past, have you had:*

Please Check YES	NO		Please Check YES	NO	
☐	☐	Permanent or extra (supernumerary) teeth removed?	☐	☐	Frequent oral habits (lip biting, chewing pen, etc)?
☐	☐	Supernumerary (extra) or congenitally missing teeth?	☐	☐	Teeth causing irritation to lip, cheek or gums?
☐	☐	Chipped or injured permanent teeth?	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	Any sensitive or sore teeth?	☐	☐	Tooth grinding or clenching?
☐	☐	Bleeding gums, bad taste or mouth odor?	☐	☐	Clicking, locking in jaw joints,"TMJ"?
☐	☐	Jaw fractures, cysts, infections?	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	Have you ever been diagnosed with gum disease?	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?
☐	☐	Frequent canker sores or cold sores?	☐	☐	Have you ever been treated for "TMJ" or "TMD" problems?
☐	☐	History of speech problems or speech therapy?	☐	☐	Any broken or missing fillings?
☐	☐	Difficulty breathing through nose?	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	Food impaction between the teeth?	☐	☐	Have you ever had an orthodontic consultation or treatment before now?
☐	☐	Mouth breathing habit or snoring at night?			

If you have checked Yes for any of the above, please explain: _____

What do you see as the main problem with your teeth: _____

Patient Health Information

List any prescription medications or non-prescription medicines, that you take.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Have you ever taken any medications to strengthen your bones? *Please describe.* _____

Do you take antibiotic pre-medication before any dental procedures? _____

Do you chew or smoke tobacco? ☐ Yes ☐ No Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any change in my medical status.

Signature: _____ Date: _____