



DATE:

patient information

PATIENT NAME... ADDRESS... HOME PHONE... BIRTH DATE... SOCIAL SECURITY #... IF PATIENT IS A MINOR, GIVE PARENT'S/GUARDIAN'S NAME... FAMILY DENTIST... WHEN LAST SEEN?... IS ANY DENTAL WORK PENDING?... PLEASE DESCRIBE... WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?... SCHOOL... SIBLING/CHILDREN INFORMATION: NAME... SEX... DOB... NAME... SEX... DOB... NAME... SEX... DOB... NAME... SEX... DOB...

responsible party information

NAME... MARITAL STATUS... RESIDENCE... MAILING ADDRESS... HOW LONG AT THIS ADDRESS?... HOME PHONE... WORK PHONE... PREVIOUS ADDRESS (IF LESS THAN 3 YEARS)... SOCIAL SECURITY #... BIRTH DATE... RELATIONSHIP TO PATIENT... EMPLOYER... OCCUPATION... # YEARS EMPLOYED... SPOUSE'S NAME... RELATIONSHIP TO PATIENT... EMPLOYER... OCCUPATION... # YEARS EMPLOYED... SOCIAL SECURITY #... BIRTH DATE... WORK PHONE...

dental insurance information

INSURED'S NAME... INSURED'S MEMBER ID #... INSURANCE COMPANY... GROUP #... PHONE... INSURANCE CO. ADDRESS... DO YOU HAVE DUAL COVERAGE? YES..... NO..... IF YES, PLEASE COMPLETE THE FOLLOWING: INSURED'S NAME... INSURED'S MEMBER ID #... INSURANCE COMPANY... GROUP #... PHONE... INSURANCE CO. ADDRESS... INSURED'S EMPLOYER...

emergency information

EMERGENCY CONTACT... PHONE... COMPLETE ADDRESS...

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE (PARENT'S SIGNATURE IF MINOR)... UPDATES (DATE & INITIAL)...

**Please complete the following health questionnaire as fully and completely as possible.
Also write in any other information that you feel might be helpful.**

WHAT ARE THE PATIENT'S OR PARENT'S MAIN CONCERNS REGARDING THE JAWS AND TEETH?

1. Crowding
2. Overbite
3. Buck teeth
4. Misalignment
5. Receded jaw
6. Prominent jaw
7. Gummy smile
8. Spacing
9. Gum disease
10. Missing teeth
11. Jaw dysfunction
12. Mouth too small
13. Clicking jaw joint
14. Irregularly shaped teeth
15. Protrusion of teeth
16. Ringing in ears
17. Headaches/facial pain
18. Neck pain
19. Jaw pain
20. Irregular facial proportions
21. Crossbite
22. Underbite
23. Openbite
24. Second opinion
25. Dentist recommended
26. Other.....

PATIENT'S CURRENT PHYSICAL HEALTH?

- | | |
|-----------------|------------|
| Excellent | Fair |
| Good | Poor |

PATIENT'S CURRENT MENTAL HEALTH?

- | | |
|-----------------|------------|
| Excellent | Fair |
| Good | Poor |

LIST ALL CURRENT MEDICATIONS TAKEN BY PATIENT:

- Heart pills (digitalis, etc.).....
- Antibiotics.....
- Pain pills.....
- Birth Control Pills.....
- Muscle relaxants.....
- Anti-anxiety/Anti-depressants.....
- Bisphosphonates.....
- Other.....

HOW OFTEN DOES THE PATIENT HAVE DENTAL CHECKUPS?

- Once per year
- Twice per year
- More than twice per year
- Only if urgent (emergency only)
- Never

HAS THE PATIENT EVER HAD, OR NOW HAVE ANY OF THE FOLLOWING CONDITIONS?

1. Anemia
2. Blood disease
3. Prolonged bleeding
4. Hepatitis
5. AIDS or HIV positive
6. Rheumatic fever
7. Malignancies, tumors or cancer
8. Heart disease or murmur
9. Tuberculosis
10. Diabetes
11. Endocrine problems
12. Bone disorders
13. Epilepsy
14. Tonsilitis
15. Mononucleosis
16. Tonsils removed
17. Adenoids removed
18. Asthma
19. Autoimmune
20. High blood pressure
21. Sleep disturbance
22. Eating disorder
23. Mouthbreathing
24. Loud snoring
25. Allergy: seasonal
26. Allergy: penicillin
27. Allergy: latex
28. Allergy: nickel
29. Antibiotic premedication
30. Severe head or facial injury
31. Finger/thumb-sucking habit
Current..... Previous.....
32. Bites nails
33. Plays musical wind instrument
34. Previous TMJ treatment
35. Previous orthodontic treatment
36. Family history orthognathic surgery
37. Repaired cleft lip/palate
38. Emotional stress
39. Osteoporosis

If a child, has the patient reached puberty?
..... Yes (APPROXIMATE DATE.....)
..... No

DOES THE PATIENT HAVE DIFFICULTY CHEWING?

- Yes
 - Teeth don't meet well
 - Pain when chewing
 - Other.....
- No

DOES THE PATIENT HAVE PAIN/CLICKING IN THE JAW JOINT?

- Yes
 - Right
 - Left
- No

DOES THE PATIENT GRIND/CLENCH THE TEETH?

- Yes
- No
- Uncertain

HAS THE PATIENT EVER BEEN TOLD THEY HAVE A TONGUE THRUST SWALLOWING PATTERN?

- Yes
- No
- Uncertain

HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAMINATION/CONSULTATION?

- Yes (WHEN.....)
- No

WHAT IS THE PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

- Wants treatment
- Treatment only if necessary
- Unwilling, but will cooperate if treatment is needed
- Uncooperative

ARE THERE ANY MEDICAL, DENTAL, OR SURGICAL PROBLEMS WHICH HAVE NOT BEEN COVERED ON THIS FORM?

- Yes
- No

SIGNATURE OF PERSON FILLING OUT FORM

PRINTED NAME

DATE

DOCTOR'S NOTES: