

PATIENT INFORMATION

Patient:

Spouse (if applicable)

Name: _____

Name: _____

Birth Date: _____ Age: _____ Male ___ Female ___

Employer: _____

Home Address: _____

Employer' Address _____

School/Grade: _____

Work Phone#: _____

Occupation/Employer: _____

Cell Phone #: _____

Employer's Address: _____

Home Phone#: _____ Work Phone# _____

Cell Phone#: _____ E-mail address _____

RESPONSIBLE PARTY INFORMATION (if patient is a minor)

Marital status: Single: _____ Married: _____ Divorced: _____ Widow(er): _____

Mother's Name: _____

Father's Name: _____

Home Address: _____

Home Address: _____

City _____ State _____ ZIP _____

City _____ State _____ Zip _____

Home#: _____ Cell #: _____

Home#: _____ Cell#: _____

Employer: _____

Employer: _____

Employer's Address: _____

Employer's Address: _____

Work Phone #: _____

Work Phone #: _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Birth Date: _____ Insured's Social Sec.# /ID# _____

Insurance Company _____ Group #: _____ Employer _____

Insurance Co. Address _____ Ins. Phone#: _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Birth Date: _____ Insured's Social Sec.# /ID# _____

Insurance Company _____ Group #: _____ Employer _____

Insurance Co. Address _____

Patient Name _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone#: _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? Please list: _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have your tonsils and adenoids been removed? What age? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you seen a physician in the last 12 months? Why? _____

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

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness/Fainting | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hay fever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

General Dentist _____ Address _____ Date of last visit _____

What concerns you most about 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? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- 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? _____
- 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 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? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
- Yes No Please list some hobbies or interests _____

Female Patients:

- Yes No Are you pregnant? Height _____ Weight _____
- Yes No Has menstruation started?

Male Patients:

- Yes No Has your voice changed? Height _____ Weight _____

