PATIENT INFORMATION **Today's Date:** ____________________

Patient's Name: ____

(Preferred to be called: __________) DOB: ______________ Age: _____ Sex: ______

Phone: Primary # H C W ______________ 2nd # H C W______________ 3rd # H C W____________

Cell Provider:__________ Preferred method(s) of confirmation: Text_____ Email______ Phone_____

Email ______________________________________

Address: ___________________________ City: ________________ PC: __________

School: ____ Grade: ______

Patient's Physician: ____________________ Patient's Dentist: ____________________

Names & ages of other children in family: ______________________________

Names of other family members in our orthodontic practice: ______________________

____

RESPONSIBLE PARTIES Adult Patients: Please complete this form for yourself & your spouse.
Parents: If completing this form for a minor, please complete parental information

Mother/ Wife/ Self

Name: ____

Address: ___________________________ City: ________________PC: __________

Primary Phone #: ______________________ Relationship to patient: ________________

Orthodontic Insurance: Y N

Father/ Husband/ Self

Name: ____

Address: ___________________________ City: ________________PC: __________

Primary Phone #: ______________________ Relationship to patient: ________________

Orthodontic Insurance: Y N

MEDICAL HISTORY

	YES	NO	
1.	☐	☐	Does the patient smoke?
2.	☐	☐	Is the patient presently under the care of a physician for a major illness?
3.	☐	☐	Does the patient have any history of a major illness?
4.	☐	☐	Is the patient in good health?
	☐	☐	Has the patient had their tonsils (circle) or adenoids (circle) removed? What age? ______
5.	☐	☐	If not removed, does the patient have regular problems with their tonsils or adenoids?
6.	☐	☐	Does the patient have a tendency to: Colds ☐ Sore throats ☐ Ear Infections ☐
7.	☐	☐	Female patients: Are you pregnant?
8.	☐	☐	If a child: Has the patient reached puberty?
9.	☐	☐	Is the patient currently taking any medications? Please list: ________________________
10.	☐	☐	Does the patient have any physical or emotional limitations?
11.	☐	☐	Does the patient have learning or psychological disabilities or need extra help with instructions?

12. Check the box if the patient had (or have) any problems with any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	Bleeding	☐	☐	Nervous Disorders	☐	☐	Bone Disorders
☐	☐	Rheumatic Fever	☐	☐	Pneumonia	☐	☐	Asthma
☐	☐	Heart Trouble	☐	☐	Anemia	☐	☐	Diabetes
☐	☐	Heart Valves	☐	☐	Fainting / Dizziness	☐	☐	Kidney Disease
☐	☐	Hemophilia	☐	☐	Liver Disease	☐	☐	Cleft Lip / Palate
☐	☐	Heart Murmur	☐	☐	Hearing	☐	☐	Epilepsy

☐ ☐ Has the patient been advised to take antibiotics prior to dental visits?
If so, by what doctor? (name & phone number) ________________________________

13. Does the patient have or has the patient been exposed to any of the following?

YES	NO		YES	NO	
☐	☐	Hepatitis	☐	☐	HIV Positive / AIDS
☐	☐	Tuberculosis	☐	☐	STD's

14. ☐ ☐ Does the patient have allergies to any drugs? Please list:
____

15. ☐ ☐ Does the patient have any other allergies? Please list:
____

Describe any other medical problems not yet covered:

____
____
____
____

DENTAL HISTORY

	YES	NO	
16.	☐	☐	Does the patient (or parent of the patient) have a concern regarding the appearance of the face? If yes, please describe: ____________
17.	☐	☐	Has the patient been told that they have an underbite?
18.	☐	☐	Is there a known family history of any family member with an underbite? If yes, what is the relationship to the patient? ____________
19.	☐	☐	Has there been any injuries to the face, teeth, or jaw joints? When? ____________
20.	☐	☐	Does the patient have speech problems? Any previous therapy? ____________
21.	☐	☐	Has the patient ever sucked the thumb or fingers? Until what age? ____________
22	☐	☐	Does the patient snore while sleeping?
23.	☐	☐	Does the patient breathe through the mouth rather than the nose? ☐ Sometimes ☐ Usually
24.	☐	☐	Are there any diagnosed or suspected airway/breathing problems?
25.	☐	☐	Has the patient ever been informed of any missing permanent teeth?
26.	☐	☐	Has the patient previously had an orthodontic consultation? When? ____________
27.	☐	☐	Has the patient ever had orthodontic treatment? When? ____________ What type of orthodontic treatment? ____________
28.	☐	☐	Has either parent had orthodontic treatment? Which? ____________
29.	☐	☐	Does the patient have pain in the jaw joint?
30.	☐	☐	Does the patient have clicking in the jaw joint? How often? ____________
31.	☐	☐	Does the patient clench and / or grind the teeth?
32.	☐	☐	Has the patient ever been diagnosed as having jaw joint (TMJ) problems? When? ____________
33.	☐	☐	Does the patient place objects (pens, pencils, etc.) in the mouth?
34.	☐	☐	Does the patient play a contact sport? Which? ____________
35.	☐	☐	Does the patient play a musical instrument? Which? ____________
36.	☐	☐	Has the patient been seen by their dentist recently? When? ____________ What was done? ____________ When are they scheduled to return? ____________ How often does the patient see their dentist? ____________
37.	☐	☐	What is the reason for this consultation? ____________

We always appreciate the referral of patients to our office and like to thank those who have made the referral. Whom may we thank for referring you to our office?

____

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Signature: ____________________________

Date: ____________________________

Relationship to patient: ____________________________

Legal Guardian (if different): ____________________________