WELCOME TO OUR OFFICE!

(Please complete both sides)

Please help us get acquainted by filling in the following important information. Date:____________________

Patient's Name: Last _______________________ First ____________________ Nickname______________ Male Female

Home Address________________________________ City__________________ State__________________ Zip_____________

Date of Birth_______________________ Age__________Yrs.___________Mos.- Home Phone Number ___________________

School _________________________ Grade ___________ Patient e-mail____

Employer ____ Business Phone _________________________

Hobbies/Interests ____SSN ____________________________________

Whom my we thank for this referral? ____

Patient's Dentist ____________________________________ Patient's Physician ______________________________________

Relatives treated here ____

FAMILY STATUS

Father or Husband's Name ____ SSN ___________________________

(Please circle one)

Occupation ____ Employed By ___________________________________

Business Address ____ Business Phone _________________

Email Address____

Mother or Wife's Name ____ SSN ___________________________

(Please circle one)

Occupation ____ Employed By ____________________________________

Business Address ____ Business Phone _________________

Email Address ____

Preferred Contact: Phone Number ______________________ E-mail ____

Patient Living With: MOTHER FATHER SELF OTHER _____________________________________

Person to be contacted if **patient or parent** cannot be reached?

Name ____ Relationship _____________________________________

Address ____ Phone _______________________

Person Financially Responsible For Account __________________________ Phone ________________ Relationship ____________

Address ____ Employer _____________________________

Is patient covered by insurance for orthodontic treatment? YES NO

If yes, by which company? ____

I understand that where appropriate, credit reports may be obtained and my signature below authorizes such reports.

Signature____ Date ________________________

MEDICAL HISTORY

Check if patient has or has had any of the following

YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Diabetes
☐	☐	Blood disorder	☐	☐	Endocrine problems
☐	☐	Prolonged bleeding	☐	☐	Epilepsy
☐	☐	Hepatitis	☐	☐	Herpes or venereal disease
☐	☐	AIDS or HIV+	☐	☐	Emotional stress
☐	☐	Jaundice	☐	☐	Frequent colds/flu
☐	☐	Rheumatic fever	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Mono
☐	☐	Heart disease or murmur	☐	☐	Asthma
☐	☐	Tuberculosis	☐	☐	Allergies (hayfever, latex, nickel, etc.)

☐ ☐ Drug Allergies. Please list: ______________________________

☐ ☐ Does patient require pre-medication for dental procedures?

Please list drugs (medicines) currently taking ______________________________

Has the patient reached puberty? ______________ When? ______________

Any other medical information which may be helpful? ______________________________

Last appointment with medical doctor ______________ Reason ______________

TMJ

YES	NO	
☐	☐	Has patient ever been treated for TMJ problems? ______________

Does patient have a history of

YES	NO		YES	NO	
☐	☐	— difficulty in mouth opening	☐	☐	— a locked jaw
☐	☐	— pain or clicking in jaw joint	☐	☐	— noises in or around the joints
☐	☐	— pain on chewing, yawning, wide opening	☐	☐	— clenching/grinding of teeth
☐	☐	— pain in ears/cheeks	☐	☐	— difficulty in chewing or swallowing
☐	☐	— a bite that is "uncomfortable" or unusual			

DENTAL HISTORY

YES	NO	
☐	☐	Are tonsils and adenoids still present?
☐	☐	Has patient ever had severe head or facial injuries? ______________
☐	☐	Has patient ever had injuries to the teeth? ______________
☐	☐	Has patient ever sucked thumb or fingers? ______________
☐	☐	Does the patient play any musical instrument that touches the lips? ______________
☐	☐	Have you been informed of any missing or extra teeth? ______________
☐	☐	Does the patient have any speech problems? ______________
☐	☐	Does patient have a problem with snoring? ______________
☐	☐	Does the patient breathe predominately through the mouth? ______________
☐	☐	Does patient have a tongue thrust? ______________
☐	☐	Previous orthodontic consultation or treatment ______________

Date of last dental visit ______________

Date of last dental cleaning ______________

Date of last dental x-rays ______________

What do you consider to be your main orthodontic problem? ______________________________

Has your dentist pointed to an orthodontic problem? ______________________________

What are your expectations from orthodontic treatment? ______________________________

Is there any other information that might be helpful? ______________________________

Signature ______________________________ Date ______________

Relationship to patient ______________________________