

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 may we thank for this referral? _____

Patient's Dentist _____ Patient's Physician _____

Relatives treated here _____

FAMILY STATUS

Father or Husband's Name _____ Date of Birth _____ SSN _____

(Please circle one)

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Email Address _____

Mother or Wife's Name _____ Date of Birth _____ 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	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or venereal disease
<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Emotional stress
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Mono
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease or murmur	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (hayfever, latex, nickel, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergies. Please list: _____			
<input type="checkbox"/>	<input type="checkbox"/>	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		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever been treated for TMJ problems? _____			
		Does patient have a history of			
<input type="checkbox"/>	<input type="checkbox"/>	— difficulty in mouth opening	<input type="checkbox"/>	<input type="checkbox"/>	— a locked jaw
<input type="checkbox"/>	<input type="checkbox"/>	— pain or clicking in jaw joint	<input type="checkbox"/>	<input type="checkbox"/>	— noises in or around the joints
<input type="checkbox"/>	<input type="checkbox"/>	— pain on chewing, yawning, wide opening	<input type="checkbox"/>	<input type="checkbox"/>	— clenching/grinding of teeth
<input type="checkbox"/>	<input type="checkbox"/>	— pain in ears/cheeks	<input type="checkbox"/>	<input type="checkbox"/>	— difficulty in chewing or swallowing
<input type="checkbox"/>	<input type="checkbox"/>	— a bite that is "uncomfortable" or unusual			

DENTAL HISTORY

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Are tonsils and adenoids still present?
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever had severe head or facial injuries? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever had injuries to the teeth? _____
<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever sucked thumb or fingers? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient play any musical instrument that touches the lips? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been informed of any missing or extra teeth? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have any speech problems? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient have a problem with snoring? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient breathe predominately through the mouth? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does patient have a tongue thrust? _____
<input type="checkbox"/>	<input type="checkbox"/>	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 _____