Patient

Today's Date ___________________
First Name _____________________ Last Name _____________________ Middle Initial ______
I prefer to be called ______________________________________ Birth Date ________________
Gender Identification ____________________ Social Security # ______________________
Home Address _________________________ City, State, Zip ________________________
Home Phone __________________________ Mobile Phone ________________________
Email Address ____
Occupation ___________________________ Employer ____________________________
Preferred method of contact ______________

Dentist(s)

Dentist's Name ________________________ Address _____________________________
Date last seen __________________________ Reason _____________________________
Any pending work? ____________ Other dental specialists now being seen? ______________
Name _______________________________ City, State, Zip ________________________
Reason ____
Name _______________________________ City, State, Zip ________________________
Reason ____

Physician(s)

Physician's Name ________________________ Date last seen _______________________
Address _________________________________ City, State, Zip ________________________
Reason ____
Physician's Name ________________________ Date last seen _______________________
Address _________________________________ City, State, Zip ________________________
Reason ____

Financial

Who is financially responsible for this account? Self Other
(If self, please continue on to the Dental Insurance section.)
Full name ____
Home Address _________________________ City, State, Zip ________________________
Home Phone __________________________ Mobile Phone ________________________
Email Address ____
Occupation ___________________________ Employer ____________________________

Dental Insurance

PRIMARY

Policy holder's full name ______________________________ Birth Date _______________

Social Security # _________________________ Relationship to patient _________________

Address ________________________________ City, State, Zip ________________________

Home Phone ____________________________ Mobile Phone ________________________

Email Address ____

Preferred method of contact: ______________

Occupation _____________________________ Employer ____________________________

Insurance Carrier ____

Group # ________________________________ ID # ________________________________

Orthodontic benefits? Yes No Not sure

SECONDARY

Policy holder's full name ______________________________ Birth Date _______________

Social Security # _________________________ Relationship to patient _________________

Address ________________________________ City, State, Zip ________________________

Home Phone ____________________________ Mobile Phone ________________________

Email Address ____

Preferred method of contact: ______________

Occupation _____________________________ Employer ____________________________

Insurance Carrier ____

Group # ________________________________ ID # ________________________________

Orthodontic benefits? Yes No Not sure

Medical and Dental Health Questionnaire

For the following questions, please select YES or NO. Answers are confidential; a thorough medical history is essential to complete orthodontic evaluation. For any questions answered YES, please provide details in the space provided at the end of the questionnaire.

Now or in the past, have you had:

Yes No 1. birth defects, hereditary, congenital or development problems or syndromes?

Yes No 2. bone fractures or major injuries to the face, head or neck?

Yes No 3. arthritis or joint problems to head, neck or jaws?

Yes No 4. cancer, tumor, radiation treatment or chemotherapy?

Yes No 5. endocrine or thyroid problems?

Yes No 6. diabetes or low or high blood sugar?

Yes No 7. kidney problems?

Yes No 8. immune system problems?

Yes No 9. Osteoporosis or bone or cartilage disorders?

Yes No 10. sexually transmitted disease?

Yes No 11. AIDS or HIV positive?

Yes No 12. hepatitis or other liver problems?

Yes No 13. polio or spinal meningitis?

Yes No 14. Mononucleosis?

Yes No 15. tuberculosis or other respiratory disease?

Yes No 16. seizures, fainting, or neurological disorders?

Yes No 17. mental or emotional health problems?

Yes No 18. learning disorder, ADHD, ADD or autism?

Yes No 19. eating disorders such as anorexia or bulimia?

Yes No 20. frequent headaches or migraines?

Yes No 21. high or low blood pressure?

Yes No 22. excessive bleeding, anemia or blood disorders?

Yes No 23. chest pain, shortness of breath, tire easily, swollen ankles?

Yes No 24. heart defects, rheumatic heart disease, angina, arteriosclerosis, coronary heart disease, congestive heart?

Yes No 25. skin disorder other than common acne?

Yes No 26. vision disorders other than nearsighted, farsighted, astigmatism?

Yes No 27. hearing or speech disorders?

Yes No 28. asthma, allergic rhinitis, hay fever, sinus problems?

Yes No 29. tonsil or adenoid problems?

Yes No 30. frequent mouth breathing?

Yes No 31. treatment with bisphosphonates such as zometa, acedia, dironel, bonita, skald for bone disorders?

Yes No 32. any allergies to anesthetics, plants, animals, antibiotics, drugs, medications, foods, metals, materials, latex?

Dental History

Now or in the past, have you had:

Yes No 1. delayed or early appearance of permanent teeth?

Yes No 2. removal of any permanent teeth?

Yes No 3. any supernumerary (extra) or congenitally missing permanent teeth?

Yes No 4. injured permanent teeth?

Yes No 5. any sensitive teeth?

Yes No 6. any lost or broken fillings?

Yes No 7. history of jaw fracture, cysts, infections?

Yes No 8. any root canals, pulpotomies?

Yes No 9. history of frequent cold sores, canker sores?

Yes No 10. speech problems, speech therapy?

Yes No 11. difficulty breathing through nose or snoring?

Yes No 12. destructive oral habits such as sucking thumb, fingers, chewing pens, ice, etc?

Yes No 13. cheek biting?

Yes No 14. tooth grinding or clenching?

Yes No 15. clicking, locking or sore jaw joints or muscles?

Yes No 16. any history of TMJ or TMD treatment?

Yes No 17. any significant problems with previous orthodontic or dental treatment?

Yes No 18. ever been diagnosed with gum disease or pyorrhea?

Yes No 19. short or abnormal roots?

Yes No 20. play instruments or any sports?

Please list any other conditions not mentioned above.

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____
____

Please list any medications taken and for what reason.

Medication ______________________________ Taken for ______________________________
Medication ______________________________ Taken for ______________________________
Medication ______________________________ Taken for ______________________________

Please list any surgeries and for what reason.

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Release and Waiver

- ❏ I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

Patient Signature ___________________________________ Date ____________________

- ❏ I have read the above questions and understand them. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Patient Signature ___________________________________ Date ____________________

Reviewed by:

Office Staff Signature ________________________________ Date ____________________
Name ____ Position _________________

Medical History updates or changes:

Changes ____
Patient Signature ___________________________________ Date ____________________
Office Staff Signature ________________________________ Date ____________________

Changes ____
Patient Signature ___________________________________ Date ____________________
Office Staff Signature ________________________________ Date ____________________