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 _____
School _____ Grade _____
Hobbies / Activities _____

Parent / Guardian

Custodial parent(s) name(s) patient lives with: _____
Other _____
Father's full name _____
Occupation _____ Method of contact _____
Home Address _____ City, State, Zip _____
Mobile Phone _____ Work Phone _____
Email Address _____

Mother's full name _____
Occupation _____ Method of contact _____
Home Address _____ City, State, Zip _____
Mobile Phone _____ Work Phone _____
Email Address _____

Dentist(s)

Dentist's Name _____ Address _____
Date last seen _____ Is patient up to date? _____
Any pending work? _____ Other dental specialists now being seen? _____
Name _____ Reason _____
Address _____

Physician(s)

Physician's Name _____ Date last seen _____
Address _____
Reason _____

Financial

Who is financially responsible for this account? (Please fill below if not listed above.)
Full name _____
Home Address _____ City, State, Zip _____
Social Security # _____ Preferred method of contact _____
Work Phone _____ Mobile Phone _____
Email Address _____
Who will be responsible for bringing patient to appointments? _____

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.

_____
_____
_____
_____

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.

_____
_____
_____
_____

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 _____