



ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both pages of this form.

TELL US ABOUT YOUR CHILD

Patient Name: Age: Birthdate: Sex: Home Address: Nickname: Home phone: City State Zip Code Cell Phone: E-mail:

Family History

Mother's Name: Occupation: Father's Name: Occupation: Siblings (name and age): Marital status of parents: Married Divorced Separated Not married Patient living with: Mother Father Both Other

Person (s) Responsible for Financial Matters

Name(s): Address: Phone (Residence): Phone (Business): Place of Employment: Name: Address: Phone (residence): Phone (business): Place of Employment:

Is patient covered by insurance for orthodontic treatment? No Yes Policy Holder? Policy Holder's Birthdate: Is insurance provided through policy holder's employer? No Yes Policy Holder ID number/SSN: Group #

PLEASE SUPPLY INSURANCE FORMS IF YOU WOULD LIKE US TO FILE FOR YOUR REIMBURSEMENT.

FAMILY DENTIST FAMILY PHYSICIAN REFERRED BY Name: Address: City, State:

Medical History

Has the patient ever had:

- Allergy Anemia Arthritis Asthma Bleeding Cancer Cold Sores Diabetes Endocrine Problems Emotional Problems Epilepsy Seizures Headaches/Migraine Heart Condition/Murmur Head or Face Injury Hepatitis Herpes HIV Positive Kidney Disease Oral Ulcer Previous Surgery Rheumatic Fever Thyroid Problems Tuberculosis Other (Describe below)

Comments:

ACHIEVE THE ULTIMATE SMILE

Has the patient been under the care of a physician during the past two years, other than for routine examination? No Yes

Condition: \_\_\_\_\_

Does the patient require premedication for dental procedures? No Yes

Present drugs or medication: \_\_\_\_\_

Birth defects, congenital problems: \_\_\_\_\_

Has the patient reached puberty (menstruation, voice change, hair) No Yes How long ago? \_\_\_\_\_

**Respiratory History** Does the patient:

1. Have allergies to: Seasonal grasses: \_\_\_\_\_ Food: \_\_\_\_\_ Drugs: \_\_\_\_\_ Latex: \_\_\_\_\_

2. Breathe through the mouth? Seldom Sometimes Usually

3. Snore when sleeping? No Yes

4. Have frequent colds? No Yes

5. Have frequent "stuffy nose"? No Yes

6. Have frequent sore throat or tonsillitis? No Yes

7. Have chewing or swallowing difficulties? No Yes

Has the patient received medical treatment from allergist or ear, nose, and throat specialist? No Yes

If Yes: When \_\_\_\_\_ By whom: \_\_\_\_\_

Nasal Surgery: \_\_\_\_\_ Tonsils removed: \_\_\_\_\_ Adenoids removed: \_\_\_\_\_

**Dental and Temporomandibular Joint History**

Has the patient had any unusual dental experiences? No Yes

Specify: \_\_\_\_\_

Date of last dental checkup: \_\_\_\_\_ Were patient's teeth cleaned? No Yes

Has the patient ever been treated for TMJ ("Jaw Joint") problems No Yes

Does the patient have:

1. difficulty in mouth opening? No Yes

2. pain or clicking in jaw joint? No Yes

3. pain on chewing, yawning or wide opening? No Yes

4. pain in or about the ears or cheeks? No Yes

5. a bite that feels "uncomfortable" or "unusual"? No Yes

6. a jaw that "locks," "gets stuck" or "goes out"? No Yes

7. noises in or from the jaw joints? No Yes

The following habits are of interest. List information as it pertains to this patient:

1. Thumb/finger/lip sucking until (age) \_\_\_\_\_ No Yes

2. Grinding or clenching of teeth No Yes

3. Tongue thrusting or other functional problem No Yes

Has the patient had a previous orthodontic consultation? No Yes Or treatment? No Yes

Date: \_\_\_\_\_ Dr: \_\_\_\_\_ City, State: \_\_\_\_\_

Why did patient seek this consultation? \_\_\_\_\_

What is the primary problem? \_\_\_\_\_

What is expected from orthodontic treatment? \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_