Patient Information Form

Welcome to our office. Please assist us by completing the following questions that apply...

Patient's Name: _____ Today's Date: _____

Preferred Name:_____ Birthdate: _____ Age: _____ Male ____ Female ___

Address: _____ City: _____ State: _____ Zip Code:_____

Contact Telephone Number: _____ School: _____ Grade: _____

Contact Email address: _____

Occupation: _____

Employed By: _____ Work Phone :( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Person Financially Responsible: _____ Telephone :( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

If Patient is under 21:

Parent/Guardian's Name: _____ Occupation: _____

Employed By: _____ Work Phone :( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Parent/Guardian's Name: _____ Occupation: _____

Employed By: _____ Work Phone :( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

If the patient is covered by dental insurance, please answer the following questions.

Name of the Policy Holder (Employee): _____ ID#_____ Birthdate: _____

Dental Insurance Company Name: _____ Group #_____

Other Dental Insurance Coverage? Yes No

Other Dental Insurance Company Name: _____ Group #_____

Name of the Other Policy Holder (Employee): _____ ID#_____ Birthdate: _____

Do the Dental Insurance Plans cover Orthodontic Treatment? Yes No

Please have your insurance card available to obtain the insurance company address and telephone number.

How did you become aware of our office? _____

Or whom may we thank for your referral? _____

_____ Date _____

Signature of Patient, Parent, or Guardian

Consent for Orthodontic Exam

Your answers to the following medical and dental questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential.

Patient's Name: _____ **Date:** _____

Medical History

Physician's Name: _____ Address: _____ Phone: _____

Have you experienced any health problems?	☐ No ☐ Yes	Explain:	_____
Any major change in your health recently?	☐ No ☐ Yes	Explain:	_____
Are you currently under physician's care?	☐ No ☐ Yes	Explain:	_____
Are you currently taking medications?	☐ No ☐ Yes	List:	_____
Are you allergic to any medications or metals?	☐ No ☐ Yes	List:	_____
Have you received a blood transfusion?	☐ No ☐ Yes	Reason:	_____
Have your tonsils or adenoids been removed?	☐ No ☐ Yes	When:	_____
Have you been in a risk group for AIDS?	☐ No ☐ Yes	Explain:	_____

Do you have any of the following conditions?

Heart Murmur	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Emotional Problems	☐ No	☐ Yes
Heart Surgery	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Frequent Headaches	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes	Nervous/Anxious	☐ No	☐ Yes
Endocrine Disorders	☐ No	☐ Yes	Liver Disease	☐ No	☐ Yes	Cancer	☐ No	☐ Yes
Prolonged Bleeding	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Bone Disorders	☐ No	☐ Yes
Anemia	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Growth Disorders	☐ No	☐ Yes
Blood Disorders	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Mouth Breather	☐ No	☐ Yes
Developmental Disorders	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Herpes (Fever Blisters)	☐ No	☐ Yes
Hives/Rash	☐ No	☐ Yes	Fainting	☐ No	☐ Yes	Tonsillitis	☐ No	☐ Yes

Is there any other condition or problem that you think we should know about? _____

Dental History

Dentist's Name: _____ Address: _____ Phone: _____

Frequency of dental checkups: ☐ Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never Date of Last Visit: _____

Is there any unfinished care to be completed with your dentist?	☐ No ☐ Yes	Explain:	_____
Are you frightened about dental treatment?	☐ No ☐ Yes	Explain:	_____
Have you had an unpleasant experience in a dental office?	☐ No ☐ Yes	Explain:	_____
Have you had any head or dental injuries, in your life?	☐ No ☐ Yes	Explain:	_____
Have teeth (either primary or permanent) been removed?	☐ No ☐ Yes		
Have you consulted an orthodontist previously?	☐ No ☐ Yes	Whom:	_____
Have you had any previous orthodontic treatment?	☐ No ☐ Yes	With whom:	_____
If yes, are you satisfied with prior orthodontic treatment?	☐ No ☐ Yes	Explain:	_____
Have you noticed any changes in your bite or alignment recently?	☐ No ☐ Yes	Explain:	_____
Do you play any musical instrument?	☐ No ☐ Yes	Which:	_____

What are the chief concerns you have related to the position of your teeth or bite?

☐ Appearance ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate: _____

What concern has your dentist(s) expressed concerning your bite or dental alignment?

- ☐ Wear or fracture of teeth
- ☐ Bone or gum tissue loss
- ☐ Alignment of teeth prior to restorative dental work (crowns, bridges, etc.)
- ☐ Difficulty with cleaning related to alignment of teeth
- ☐ Jaw joint or muscle tightness or discomfort
- ☐ Other: _____

Please check if there is a history of:

- ☐ Clenching of teeth
- ☐ Grinding teeth
- ☐ Speech problems (if so, which sounds_____)
- ☐ Muscular soreness around head & neck
- ☐ Headaches (more than normal)
- ☐ Jaw joint soreness: Right Left
- ☐ Jaw joint clicking: Right Left
- ☐ Mouth breathing while: ☐ Awake ☐ Asleep

Is there any other information that may be helpful? _____

_____ _____ Reviewed by: _____

Patient's, Parent's, or Guardian's Signature if patient is minor Date