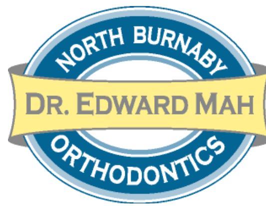

PATIENT INFORMATION

Name: ____________________ Nickname: ____________________

Address: ____________________

City: ____________________ Postal Code: ____________ No. Years at This Address: ______

Phone: (____) ______________ Work: (____) ______________ Email: ____________________

Birthdate: ____________ Age: ______ Sex: ☐ M ☐ F School: ____________________

Hobbies/Interests: ____________________

Has any member of your family undergone orthodontic treatment? ☐ Yes ☐ No Name: ______________

Do you know anyone being treated in this office? ☐ Yes ☐ No Name: ____________________

Whom may we thank for referring you? ____________________

Reason for seeking treatment: ____________________

PARENT/GUARDIAN AND FINANCIALLY RESPONSIBLE PARTIES

#1 Name: ____________________ Marital Status: ______________

Address: ____________________

Phone: (____) ______________ Work: (____) ______________ Email: ____________________

Relationship to Patient: ____________________ Birthdate: ______________

Employer: ____________________ Occupation: ______________

Employer Address: ____________________

No. Years at Employer ______ S.I.N. ______________ Do You Have Orthodontic Insurance? ☐ Yes ☐ No

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#2 Name: ____________________ Marital Status: ______________

Address: ____________________

Phone: (____) ______________ Work: (____) ______________ Email: ____________________

Relationship to Patient: ____________________ Birthdate: ______________

Employer: ____________________ Occupation: ______________

Employer Address: ____________________

No. Years at Employer ______ S.I.N. ______________ Do You Have Orthodontic Insurance? ☐ Yes ☐ No

EMERGENCY CONTACT

Name of nearest relative not living with you: ____________________

Address: ____________________

Phone: (____) ______________ Work: (____) ______________ Relationship to Patient: ______________

OVER ⇒

DENTAL HISTORY

Dentist: ______________________________ Last Cleaning: __________ Last X-rays: __________

Have you had any injuries to the mouth/jaw area? If yes, please explain: ______________________________

Any pain or clicking upon mouth opening/closing? If yes, please explain: ______________________________

Is this your first orthodontic visit? If no, please explain: ______________________________

Reason for referral: ______________________________

Please list any experiences or problems you would like the doctor to be aware of: ______________________________

____

If the patient is a child, is there any presence of: ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Mouth Breathing

HEALTH HISTORY

Physician: ______________________________ Date of Last Visit: ______________________

Current medical condition(s), medication(s): ______________________________

Have you been hospitalized in the last two years? If yes, please explain: ______________________________

____

Have you had... [Please check (✓) each box if the answer is "Yes", leave blank if "No"]

- ☐ Adenoidectomy
- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Emotional problems
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or dizziness
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hepatitis, type
- ☐ Herpes
- ☐ High ☐ Low blood pressure
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease
- ☐ Nervous problems
- ☐ Pregnant, due date
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling in ankles or feet
- ☐ Swollen neck glands
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tonsillectomy
- ☐ Transplanted organs
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers – where?
- ☐ Venereal disease
- ☐ Weight change – why?

Other health complications not listed above:
If the patient's medical status changes, please notify us as soon as possible.

Are you allergic to:

- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Iodine
- ☐ Sulfa
- ☐ Latex
- ☐ Nickel
- ☐ Local anesthetic
- ☐ Other:

Name of responsible party: ______________________________ Relationship: __________________

Signature of responsible party: Date: ______________________