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: _____

If recommended, are you prepared to begin orthodontic treatment today? ___Yes ___No

If no, why not? _____

PARENT/GUARDIAN AND FINANCIALLY RESPONSIBLE PARTIES

Name: _____ Marital Status: _____

Address: _____

Phone: (____) _____ Work: (____) _____ Email: _____

Relationship to Patient: _____ Birthdate: _____

Employer: _____ Occupation: _____

Do You Have Orthodontic Insurance? □ Yes □ No Insurance Company Name: _____

Insured Name: _____ Group #: _____ Policy #: _____

Orthodontic Insurance Coverage: % _____ Up To $ _____

Name: _____ Marital Status: _____

Address: _____

Phone: (____) _____ Work: (____) _____ Email: _____

Relationship to Patient: _____ Birthdate: _____

Employer: _____ Occupation: _____

Do You Have Orthodontic Insurance? □ Yes □ No Insurance Company Name: _____

Insured Name: _____ Group #: _____ Policy #: _____

Orthodontic Insurance Coverage: % _____ Up To $ _____

EMERGENCY CONTACT

Name of nearest relative not living with you: _____

Address: _____

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

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: _____

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
- ☐ Cough, persistent/bloody
- ☐ COVID
- ☐ 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, stomach
- ☐ Venereal disease
- ☐ Weight change, unexplained

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: _____

Due to patient privacy concerns, only patients are allowed in the treatment area. All others must remain in the waiting room or outside the office unless asked to enter the treatment area. If requested, a staff member will update you on the treatment performed.