

Patient Information

\*First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ \*Last Name: \_\_\_\_\_
Nickname: \_\_\_\_\_ \*Birthdate: \_\_\_\_\_ \*Gender: [ ] Male [ ] Female
\*Address: \_\_\_\_\_ \*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_
Marital Status: [ ] Single [ ] Married [ ] Partnered [ ] Widowed [ ] Divorced [ ] Separated
How long at this address? \_\_\_\_\_ Previous Address: \_\_\_\_\_
\*Main Phone# \_\_\_\_\_ 2nd/Cell Phone: \_\_\_\_\_
Email: \_\_\_\_\_ Work Phone #: \_\_\_\_\_
Birthdate: \_\_\_\_\_ SS# \_\_\_\_\_
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long? \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Main Phone #: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_
Please list the names of any friends or family currently in the practice: \_\_\_\_\_
Whom may we thank for referring you to our practice? \_\_\_\_\_

Confidential Financial Party Information

[ ] Do you have Dental Insurance?
Subscriber Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_
Subscriber ID/SS #: \_\_\_\_\_ Group #: \_\_\_\_\_
Insurance Co: \_\_\_\_\_ Ins Co Phone #: \_\_\_\_\_
Subscriber's Employer: \_\_\_\_\_ Subscriber Zip: \_\_\_\_\_
Relationship to patient: \_\_\_\_\_

[ ] Do you have additional dental coverage? If so, please fill out information below:

Subscriber #2 Name: \_\_\_\_\_ D.O.B. : \_\_\_\_\_
Subscriber ID/SS #: \_\_\_\_\_ Group #: \_\_\_\_\_
Insurance Co: \_\_\_\_\_ Ins Co Phone #: \_\_\_\_\_
Subscriber's Employer: \_\_\_\_\_ Subscriber Zip: \_\_\_\_\_
Relationship to patient: \_\_\_\_\_

Dental History

Dentist Name: \_\_\_\_\_ Dentist Phone # \_\_\_\_\_
Last Dental Visit: \_\_\_\_\_ Check-up Frequency: \_\_\_\_\_

Yes [ ] No [ ] Does patient need to premedicate prior to visit?
Yes [ ] No [ ] Has the patient had an orthodontic consult or treatment?
What is the patient's main orthodontic concern? \_\_\_\_\_

*(Dental History continued)*

**Please indicate YES or NO if you have had any of the following, either now or in the past.**

- |  |  |
|--|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Brush teeth daily                         | Yes <input type="checkbox"/> No <input type="checkbox"/> Mouth breathing                                     |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Floss teeth daily                         | Yes <input type="checkbox"/> No <input type="checkbox"/> Numerous fillings                                   |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Flouride treatments                       | Yes <input type="checkbox"/> No <input type="checkbox"/> Periodontal (gum) problems/recession                |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Have wisdom teeth been removed            | Yes <input type="checkbox"/> No <input type="checkbox"/> Previous root canal therapy                         |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Is all dental work complete at this time? | Yes <input type="checkbox"/> No <input type="checkbox"/> Teeth sensitive to hot or cold                      |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Problems with food trapped between teeth  | Yes <input type="checkbox"/> No <input type="checkbox"/> Teeth that irritate tongue, cheek, lip, etc         |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Any missing permanent teeth               | Yes <input type="checkbox"/> No <input type="checkbox"/> Abnormal swallowing (tongue thrust)                 |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Any extra permanent teeth                 | Yes <input type="checkbox"/> No <input type="checkbox"/> Bad taste/mouth odor                                |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bleeding gums                             | Yes <input type="checkbox"/> No <input type="checkbox"/> Difficulty sleeping                                 |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Chipped or injured permanent teeth        | Yes <input type="checkbox"/> No <input type="checkbox"/> Frequently chew gum                                 |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Clench or grind teeth                     | Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent headaches                                  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Discomfort of teeth or gums               | Yes <input type="checkbox"/> No <input type="checkbox"/> Oral habits (thumb/finger sucking, lip/nail biting) |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent canker sores or cold sores       | Yes <input type="checkbox"/> No <input type="checkbox"/> Snores during sleep                                 |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Frequent sore throats                     | Yes <input type="checkbox"/> No <input type="checkbox"/> Speech problems/therapy                             |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Injury to face, jaw, teeth, or mouth      | Yes <input type="checkbox"/> No <input type="checkbox"/> Apprehensive about dental care                      |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Jaw fractures, cysts, mouth infections    | Yes <input type="checkbox"/> No <input type="checkbox"/> Strong gag reflex                                   |

**If any of the above dental questions were answered YES, please explain:**

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- |   |  |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> History of jaw joint problems?                               | Yes <input type="checkbox"/> No <input type="checkbox"/> Has patient's jaw ever locked?  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient clench their teeth?                             | Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient's bite feel uncomfortable or unusual?                                  |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient notice clicking or popping in either jaw joint? | Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient experience soreness in the muscles of their face or around their ears? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does patient have difficulty chewing or opening their mouth? | Yes <input type="checkbox"/> No <input type="checkbox"/> Has patient been diagnosed or treated for "TMJ" or "TMD" problems?                  |

**If any of the above TMJ questions were answered YES, please explain:**

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**Medical History**

Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Patient Health: \_\_\_\_\_

Yes  No  Has there been any change in the patient's general health within the last year? \_\_\_\_\_

Yes  No  Is the patient now under the care of a physician (other than routine)?  
If yes, what is being treated? \_\_\_\_\_

Yes  No  Has the patient had a serious illness/hospitalization in the past 5 years?  
If yes, what for? \_\_\_\_\_

List any medications currently being taken by the patient (include non-prescription) \_\_\_\_\_  
\_\_\_\_\_

*(Medical History continued)*

**Allergies or drug reaction to:**

Yes <input type="checkbox"/> No <input type="checkbox"/> Latex	Yes <input type="checkbox"/> No <input type="checkbox"/> Penicillin or other antibiotics
Yes <input type="checkbox"/> No <input type="checkbox"/> Sulfa drugs	Yes <input type="checkbox"/> No <input type="checkbox"/> Aspirin, Ibuprofen, Tylenol
Yes <input type="checkbox"/> No <input type="checkbox"/> Local anesthetics	Yes <input type="checkbox"/> No <input type="checkbox"/> Codeine or other narcotics
Yes <input type="checkbox"/> No <input type="checkbox"/> Metal allergy/Nickel	Yes <input type="checkbox"/> No <input type="checkbox"/> Plastic allergy

List any drug allergies or sensitivities (not listed above) that the patient may have:

\_\_\_\_\_

**Please indicate YES or NO if you have had any of the conditions listed below either now or in the past.**

Yes <input type="checkbox"/> No <input type="checkbox"/> Mitral valve prolapse/Heart Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/> Hearing impairment
Yes <input type="checkbox"/> No <input type="checkbox"/> Damaged or artificial heart valves	Yes <input type="checkbox"/> No <input type="checkbox"/> Seizures/Epilepsy/Neurological disorders
Yes <input type="checkbox"/> No <input type="checkbox"/> Congenital heart defect	Yes <input type="checkbox"/> No <input type="checkbox"/> Lung Disease/Tuberculosis/Emphysema
Yes <input type="checkbox"/> No <input type="checkbox"/> Heart Disease/Stroke/Angina	Yes <input type="checkbox"/> No <input type="checkbox"/> Pneumonia/Fever
Yes <input type="checkbox"/> No <input type="checkbox"/> Rheumatic Fever/Scarlet Fever	Yes <input type="checkbox"/> No <input type="checkbox"/> Chronic fatigue
Yes <input type="checkbox"/> No <input type="checkbox"/> Kidney disease	Yes <input type="checkbox"/> No <input type="checkbox"/> Thyroid/Endocrine problems
Yes <input type="checkbox"/> No <input type="checkbox"/> Liver disease/Jaundice/Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/> Hormone therapy
Yes <input type="checkbox"/> No <input type="checkbox"/> Blood disorders/Anemia/Hemophilia/Sickle Cell	Yes <input type="checkbox"/> No <input type="checkbox"/> Nervous disorders
Yes <input type="checkbox"/> No <input type="checkbox"/> HIV/AIDS	Yes <input type="checkbox"/> No <input type="checkbox"/> Substance abuse problems (past or present)
Yes <input type="checkbox"/> No <input type="checkbox"/> Hypertension/High blood pressure	Yes <input type="checkbox"/> No <input type="checkbox"/> Treated for emotional problems
Yes <input type="checkbox"/> No <input type="checkbox"/> Low blood pressure/Fainting spells	Yes <input type="checkbox"/> No <input type="checkbox"/> Persistent swollen neck glands
Yes <input type="checkbox"/> No <input type="checkbox"/> Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/> Tonsils/Adenoids removed
Yes <input type="checkbox"/> No <input type="checkbox"/> Cancer/Received radiation therapy	Yes <input type="checkbox"/> No <input type="checkbox"/> Large tonsils
Yes <input type="checkbox"/> No <input type="checkbox"/> Stomach ulcer/Hyperacidity	Yes <input type="checkbox"/> No <input type="checkbox"/> Diagnosed with sleep apnea
Yes <input type="checkbox"/> No <input type="checkbox"/> Handicaps/Disabilities	Yes <input type="checkbox"/> No <input type="checkbox"/> Persistent cough
Yes <input type="checkbox"/> No <input type="checkbox"/> Arthritis/Joint problems	Yes <input type="checkbox"/> No <input type="checkbox"/> Sinus trouble
Yes <input type="checkbox"/> No <input type="checkbox"/> Bone fractures/Trauma to face or jaw	Yes <input type="checkbox"/> No <input type="checkbox"/> Asthma/Hay fever
Yes <input type="checkbox"/> No <input type="checkbox"/> Bone disorders/Bone loss	Yes <input type="checkbox"/> No <input type="checkbox"/> Females: Are you pregnant?
Yes <input type="checkbox"/> No <input type="checkbox"/> Prosthetic joints	Yes <input type="checkbox"/> No <input type="checkbox"/> Neck or Shoulder Pain

- **I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.**
- **I understand that where appropriate, credit bureau information may be obtained.**
- **I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.**

*Electronic Signature:* By entering the last four digits of your Social Security Number (SSN) or Tax ID Number (TIN) and checking "I Agree" you certify that this electronic form is the same as an original signature, binding by law and demonstrates your expression of authorization.

\_\_\_\_\_  I Agree

Print Name Last 4 digits of my SSN/TIN Date

*I have verbally reviewed the medical/dental information with the patient.*

Signature of \_\_\_\_\_ Date: \_\_\_\_\_

Orthodontist: \_\_\_\_\_

**FOR FUTURE UPDATES:**

Are there any changes in your medical or dental status? Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Orthodontist Signature \_\_\_\_\_ Date \_\_\_\_\_

Are there any changes in your medical or dental status? Yes  No

If yes, please explain \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Orthodontist Signature \_\_\_\_\_ Date \_\_\_\_\_