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

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

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

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

## 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 ☐ | No ☐ | Latex | Yes ☐ | No ☐ | Penicillin or other antibiotics |
| Yes ☐ | No ☐ | Sulfa drugs | Yes ☐ | No ☐ | Aspirin, Ibuprofen, Tylenol |
| Yes ☐ | No ☐ | Local anesthetics | Yes ☐ | No ☐ | Codeine or other narcotics |
| Yes ☐ | No ☐ | Metal allergy/Nickel | Yes ☐ | No ☐ | 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 ☐ | No ☐ | Mitral valve prolapse/Heart Murmur | Yes ☐ | No ☐ | Hearing impairment |
| Yes ☐ | No ☐ | Damaged or artificial heart valves | Yes ☐ | No ☐ | Seizures/Epilepsy/Neurological disorders |
| Yes ☐ | No ☐ | Congenital heart defect | Yes ☐ | No ☐ | Lung Disease/Tuberculosis/Emphysema |
| Yes ☐ | No ☐ | Heart Disease/Stroke/Angina | Yes ☐ | No ☐ | Pneumonia/Fever |
| Yes ☐ | No ☐ | Rheumatic Fever/Scarlet Fever | Yes ☐ | No ☐ | Chronic fatigue |
| Yes ☐ | No ☐ | Kidney disease | Yes ☐ | No ☐ | Thyroid/Endocrine problems |
| Yes ☐ | No ☐ | Liver disease/Jaundice/Hepatitis | Yes ☐ | No ☐ | Hormone therapy |
| Yes ☐ | No ☐ | Blood disorders/Anemia/Hemophilia/Sickle Cell | Yes ☐ | No ☐ | Nervous disorders |
| Yes ☐ | No ☐ | HIV/AIDS | Yes ☐ | No ☐ | Substance abuse problems (past or present) |
| Yes ☐ | No ☐ | Hypertension/High blood pressure | Yes ☐ | No ☐ | Treated for emotional problems |
| Yes ☐ | No ☐ | Low blood pressure/Fainting spells | Yes ☐ | No ☐ | Persistent swollen neck glands |
| Yes ☐ | No ☐ | Diabetes | Yes ☐ | No ☐ | Tonsils/Adenoids removed |
| Yes ☐ | No ☐ | Cancer/Received radiation therapy | Yes ☐ | No ☐ | Large tonsils |
| Yes ☐ | No ☐ | Stomach ulcer/Hyperacidity | Yes ☐ | No ☐ | Diagnosed with sleep apnea |
| Yes ☐ | No ☐ | Handicaps/Disabilities | Yes ☐ | No ☐ | Persistent cough |
| Yes ☐ | No ☐ | Arthritis/Joint problems | Yes ☐ | No ☐ | Sinus trouble |
| Yes ☐ | No ☐ | Bone fractures/Trauma to face or jaw | Yes ☐ | No ☐ | Asthma/Hay fever |
| Yes ☐ | No ☐ | Bone disorders/Bone loss | Yes ☐ | No ☐ | Females: Are you pregnant? |
| Yes ☐ | No ☐ | Prosthetic joints | Yes ☐ | No ☐ | 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 demonsrates your expression of authorization.

**Print Name** _____ **Signature** _____ **Date** _____

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

*Signature of Orthodontist:* _____ *Date:* _____

***FOR FUTURE UPDATES:***

Are there any changes in your medical or dental status?
If yes, please explain _____ **Yes** ☐ **No** ☐

_____ Patient Signature _____ Date

_____ Orthodontist Signature _____ Date

Are there any changes in your medical or dental status?
If yes, please explain _____ **Yes** ☐ **No** ☐

_____ Patient Signature _____ Date

_____ Orthodontist Signature _____ Date