

Patient Biographical Information

*First Name: _____ Middle Initial: _____ *Last Name: _____

Nickname: _____ *Birthdate: _____ *Gender: Male Female

*Address: _____ *City: _____ *State: _____ *Zip: _____

Home Phone #: _____ Child's Cell: _____ Child's Email: _____

*Parent's or guardian's name accompanying child today: _____

*Who does the patient live with? _____

Emergency Contact: _____ Main Phone #: _____ Relationship to patient: _____

Please list the names of any friends or family currently in the practice: _____

List any sports, hobbies, or musical instruments played: _____

Whom may we thank for referring you to our practice? _____

Confidential Financial Party Information

Parent/Guardian #1 - Name of parent or legal guardian who will be responsible for the account:

*First Name: _____ Middle Initial: _____ *Last Name: _____ Relationship to patient: _____

*Check if address is the same as the patient's; if not, complete address below

*Address: _____ *City: _____ *State: _____ *Zip: _____

Marital Status: Single Married Partnered Widowed Divorced Separated

How long at this address? _____ If less than 2 years, previous address: _____

* Phone Numbers Main: _____ 2nd/Cell: _____ Work: _____

Email: _____ * D.O.B. : _____

Occupation: _____ Employer: _____ How long? _____

Do you have orthodontic coverage? If so, please name the Insurance Company below:

Subscriber #1 Name: _____ Group #: _____

Subscriber ID/SS #: _____ Ins Co Phone #: _____

Insurance Co: _____

Parent/Guardian #2:

*First Name: _____ Middle Initial: _____ *Last Name: _____ Relationship to patient: _____

*Check if address is the same as the patient's; if not, complete address below

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

* Phone Numbers Main: _____ 2nd/Cell: _____ Work: _____

Email: _____ D.O.B. : _____

Occupation: _____ Employer: _____ How long? _____

Do you have DUAL orthodontic coverage? If so, please name the Insurance Company below:

Subscriber #2 Name: _____ Group #: _____

Subscriber ID/SS #: _____ Ins Co Phone #: _____

Insurance Co: _____

Dental History

Dentist Name: _____ Dentist Phone # _____

Last Dental Visit: _____ Check-up Frequency: _____

(Dental History continued)

Yes No **Does patient need to premedicate prior to visit?**
Yes No Has the patient had a previous orthodontic consult or treatment?
What is the patient's/parents' main orthodontic concern? _____

Please indicate YES or NO if the patient has 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 or extra permanent teeth | Yes <input type="checkbox"/> No <input type="checkbox"/> Abnormal swallowing (tongue thrust) |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Bad taste/mouth odor | Yes <input type="checkbox"/> No <input type="checkbox"/> Apprehensive about dental care |
| 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"/> Strong Gag Reflex |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Jaw fractures, cysts, mouth infections | |

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

- | | |
|---|--|
| 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: _____

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) _____

Height: _____ Weight: _____ How much has patient grown in the last year: _____ Yes No Has patient begun puberty?

Yes No If patient is a girl, has menstruation begun? If patient is a boy, has their voice changed or have facial hair?

Yes No Is patient adopted? Yes No If so, are they aware?

Yes No Has either biological parent ever had orthodontic treatment?

(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 the patient has 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"/> ADD/ADHD

Patients Under 18

- ***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 child's 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.

Print Parent/Guardian Name	Parent/Guardian Signature	Date
<i>I have verbally reviewed the medical/dental information with the parent/guardian.</i>		
Signature of Orthodontist: _____		Date: _____

FOR FUTURE UPDATES:

Are there any changes in your child's medical or dental status?
If yes, please explain

Yes No

Parent/Guardian Signature	Date
Orthodontist Signature	Date

Are there any changes in your child's medical or dental status?
If yes, please explain

Yes No

Parent/Guardian Signature	Date
Orthodontist Signature	Date