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 ☐ 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 or extra permanent teeth		Yes ☐ No ☐ Abnormal swallowing (tongue thrust)	
Yes ☐ No ☐ Bad taste/mouth odor		Yes ☐ No ☐ Apprehensive about dental care	
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 ☐ Strong Gag Reflex	
Yes ☐ No ☐ Jaw fractures, cysts, mouth infections			

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) _____

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 ☐ 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 the patient has 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 ☐ 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 demonsrates your expression of authorization.

Print Name of Parent/Guardian _____ **Last 4 digits of my SSN/TIN** _____ **Date** _____ ☐ **I Agree**

I have verbally reviewed the medical/dental information with the parent/guardian.

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 _____