PATIENT

Patient's Name: ____ Date of Birth: ___/___/___

(LAST) (FIRST) (Preferred Name)

SS#: _____-_____-_____ Marital Status: ________ EMAIL: ____________________________________

S / M / D / W Would you like to receive online communication from us?

Address: ____

STREET ADDRESS CITY STATE ZIP

Home #: (_____) ________-_________ Work #: (______) ______-_________ Cell #: (______) ______-__________

Occupation: ______________________________ Employer: ____

Referred By: ______________________________

# of family members treated @ ORTHODONTIC SPECIALISTS. ___ Names:____

PARENT/SPOUSE/GUARDIAN

Father/Husband/Guardian: ____Date of Birth: ___/___/___

(LAST) (FIRST)

SS#: _____-_____-_____ Marital Status: ________ EMAIL: ____________________________________

S / M / D / W Would you like to receive online communication from us?

Address: ____

STREET ADDRESS CITY STATE ZIP

Home #: (_____) ________-_________ Work #: (______) ______-_________ Cell #: (______) ______-__________

Occupation: ______________________________ Employer: ____

Financially Responsible for account? YES________ NO _______

Mother/Wife/Guardian: ____Date of Birth: ___/___/___

(LAST) (FIRST)

SS#: _______-_______-_______ Marital Status: ________ EMAIL: ____________________________________

S / M / D / W Would you like to receive online communication from us?

Address: ____

STREET ADDRESS CITY STATE ZIP

Home #: (_____) ________-_________ Work #: (______) ______-_________ Cell #: (______) ______-__________

Occupation: ______________________________ Employer: ____

Financially Responsible for account? YES________ NO _______

DENTIST

Name: ____ Phone: ________________________________

Last Seen ___________ Reason ___________________________ Next Appointment_________________

Other dentists/dental specialists now being seen:

Name: ____ City/State: _____________________________________

Phone: ____ Reason ______________________________________

GENERAL INFORMATION

What interests or concerns do you have about your/your child's teeth? ____

What interests or concerns do you or your child have about your/his/her teeth?___________________________________

How do you/your child feel about orthodontic treatment? ____

Who suggested that you/your child might need orthodontic treatment? ____

Why did you select our office? ____

Describe any previous orthodontic treatment or consultations. ____

Do you/your child play a musical instrument or play any sports? ____

DENTAL INSURANCE

PRIMARY

INSURANCE CO. NAME: ______________________________

INSURANCE CO. ADDRESS: ____________________________

INSURANCE CO. PHONE #: ____________________________

ID #: ____

LIFETIME MAXIMUM BENEFIT: _________________________

INSURED'S NAME: ___________________________________

INSURED'S RELATION TO PATIENT: ___________________

INSURED'S DATE OF BIRTH: ____/____/____

INSURED'S EMPLOYER: _______________________________

SECONDARY

INSURANCE CO. NAME: ____________________________

INSURANCE CO. ADDRESS: __________________________

INSURANCE CO. PHONE #: __________________________

ID #: ____

LIFETIME MAXIMUM BENEFIT: ______________________

INSURED'S NAME: _________________________________

INSURED'S RELATION TO PATIENT: _________________

INSURED'S DATE OF BIRTH: ____/____/____

INSURED'S EMPLOYER: _____________________________

RELEASE

I authorize the release of any information regarding my/my child's orthodontic treatment to my dental and/or medical insurance company.

Signature____ **Date**____________________

PHYSICIAN

Patient's Physician name: _____________________________________ Phone: ___________________________

Last Seen ____________ Reason _____________________________ Next Appointment_________________

Most recent physical exam _________________

Other physicians/health care providers being seen now:

Name: ____ City/State: ____

Phone: ____ Reason ____

Name: ____ City/State: ____

Phone: ____ Reason ____

PATIENT HEALTH INFORMATION

Do you think that any of your/your child's activities affect your/his/her face, teeth or jaws? How? ___________________

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that the patient takes.

Medication ______________________________ Taken for ____

Medication ______________________________ Taken for ____

Medication ______________________________ Taken for ____

Does the patient currently have (or ever had) a substance abuse problem? ____

Does the patient chew or smoke tobacco? ___________________________

Have you noticed any unusual changes in the patient's face or jaws? ____

Any other physical problems? ____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems?

Bleeding disorders _________ Diabetes___________ Arthritis ___________

Severe allergies ___________ Unusual dental problems_______ Jaw size imbalance___________

Other family medical conditions? _________________________________

How often does the patient brush? _______________________________ Floss? ______________________________

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. ***For the following questions, please mark yes, no or don't know/understand (dk/u).***

PATIENT MEDICAL HISTORY

Now or in the past, has the patient had:

___Yes ___ No___Dk/u Birth defects or hereditary problems
___Yes ___ No___Dk/u Bone fractures, or major injuries?
___Yes ___ No___Dk/u Any injuries to face, head or neck?
___Yes ___ No___Dk/u Arthritis or joint problems?
___Yes ___ No___Dk/u Cancer, tumor, radiation treatment or chemotherapy?
___Yes ___ No___Dk/u Endocrine or thyroid problems?
___Yes ___ No___Dk/u Diabetes or low sugar?
___Yes ___ No___Dk/u Kidney problems?
___Yes ___ No___Dk/u Immune system problems?
___Yes ___ No___Dk/u History of osteoporosis?
___Yes ___ No___Dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
___Yes ___ No___Dk/u AIDS or HIV positive?
___Yes ___ No___Dk/u Hepatitis, jaundice or other liver problems?
___Yes ___ No___Dk/u Polio, mononucleosis, tuberculosis, pneumonia?
___Yes ___ No___Dk/u Seizures, fainting spells, neurologic problems?
___Yes ___ No___Dk/u Mental health disturbance or depression?
___Yes ___ No___Dk/u History of eating disorder (anorexia, bulimia)?
___Yes ___ No___Dk/u Frequent headaches or migraines?
___Yes ___ No___Dk/u High or low blood pressure?
___Yes ___ No___Dk/u Excessive bleeding or bruising tendency, anemia?
___Yes ___ No___Dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
___Yes ___ No___Dk/u Heart defects, heart murmur, rheumatic heart disease?
___Yes ___ No___Dk/u Angina, arteriosclerosis, stroke or heart attack?
___Yes ___ No___Dk/u Skin disorder (other than common acne)?
___Yes ___ No___Dk/u Does the patient eat a well-balanced diet?
___Yes ___ No___Dk/u Vision, hearing or speech problems?
___Yes ___ No___Dk/u Frequent ear infections, colds, throat infections?
___Yes ___ No___Dk/u Asthma, sinus problems, hayfever?
___Yes ___ No___Dk/u Tonsil or adenoid condition?
___Yes ___ No___Dk/u Does the patients frequently breathe through his/her mouth?
___Yes ___ No___Dk/u Has the patient ever taken intravenous bisphosphonates such As Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
___Yes ___ No___Dk/u Has the patient ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) For bone disorders?

MEDICAL HISTORY CONTINUED…

Has the patient had allergies or reactions to any of the following:

___Yes ___ No___Dk/u Local anesthetics (novocaine, Lidocaine, xylocaine)
___Yes ___ No___Dk/u Latex (gloves, balloons)
___Yes ___ No___Dk/u Asprin
___Yes ___ No___Dk/u Ibuprofin (Motrin, Advil)
___Yes ___ No___Dk/u Penicillin
___Yes ___ No___Dk/u Other antibiotics
___Yes ___ No___Dk/u Metals (Jewelery, clothing snaps)
___Yes ___ No___Dk/u Acrylics
___Yes ___ No___Dk/u Plant pollens
___Yes ___ No___Dk/u Animals
___Yes ___ No___Dk/u Foods
___Yes ___ No___Dk/u Other substances

DENTAL HISTORY

Now or in the past, has the patient had:

___Yes ___ No___Dk/u Erupting teeth very early or very late?
___Yes ___ No___Dk/u Primary (baby) teeth remover that were not loose?
___Yes ___ No___Dk/u Permanent or extra (supernumerary) teeth removed?
___Yes ___ No___Dk/u Supernumerary (extra) or congenitally missing teeth?
___Yes ___ No___Dk/u Chipped or injured primary or permanent teeth?
___Yes ___ No___Dk/u Any sensitive or sore teeth?
___Yes ___ No___Dk/u Any lost or broken fillings?
___Yes ___ No___Dk/u Jaw fractures, cysts, infections?
___Yes ___ No___Dk/u Any teeth treated with root canals or pulpotomies?
___Yes ___ No___Dk/u Frequent canker sores or cold sores?
___Yes ___ No___Dk/u History of speech problems or speech therapy?
___Yes ___ No___Dk/u Difficulty breathing through nose?
___Yes ___ No___Dk/u Mouth breathing habit or snoring at night?
___Yes ___ No___Dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
___Yes ___ No___Dk/u Teeth causing irritation to lip, cheek or gums?
___Yes ___ No___Dk/u Tooth grinding or clenching?
___Yes ___ No___Dk/u Clicking, locking in jaw joints?
___Yes ___ No___Dk/u Soreness in jaw muscles or face muscles?
___Yes ___ No___Dk/u Has the patient been treated for "TMJ" or "TMD" problems?
___Yes ___ No___Dk/u Any broken or missing fillings?
___Yes ___ No___Dk/u Any serious trouble associated with previous dental treatment?
___Yes ___ No___Dk/u Has the patient ever been diagnosed with gum disease or pyorrhea?

RELEASE AND WAIVER

I have read the above questions and understand them. I will not hold my orthodontist or any member or his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Signature____ **Date**____________________

Updated: 3/2017