WELCOME

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please complete both sides of this form.

Patient Name:_____ Age:_____ Birthdate:_____ Sex:_____
Home Address:_____ Nickname:_____
_____ Home Phone:_____
Cell Phone: _____
School:_____ Grade:_____ E-mail:_____

FAMILY

Father's Name:_____ Living? Yes No Occupation:_____
Relationship to patient: biological step-father adoptive
Mother's Name:_____ Living? Yes No Occupation:_____
Relationship to patient: biological step-mother adoptive
Siblings (name and age):_____
Parents' Marital Status: Married Divorced Separated Not married
Patient living with: Mother_____ Father_____ Other_____

PERSON(S) RESPONSIBLE FOR FINANCIAL MATTERS

Name(s): _____ _____
Address: _____ _____
_____ _____
Home phone: _____ _____
Bus. phone: _____ _____
Place of Employment:_____ _____
SS #: _____ _____
Is the patient covered by insurance for orthodontic treatment? _____
Company? _____
PLEASE SUPPLY INSURANCE FORMS IF YOU WOULD LIKE US TO FILE FOR YOUR REIMBURSEMENT.

	PATIENT'S DENTIST	PATIENT'S PHYSICIAN	REFERRED BY
Name:			
Address:			
Phone:			

Has any other orthodontist been consulted regarding this patient? _____
Has the patient had previous orthodontic treatment (please explain)? _____
_____

Please describe any major illnesses or hospitalizations: _____
_____
_____

Does the patient have any allergies? _____
Is the patient taking any medication(s)? _____
_____

Has the patient been under the care of a physician during the past 3 years, other than for routine examination (please explain)? _____
_____
_____

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Medical History

Has the patient ever had (please circle):

Abnormal blood pressure	Emotional problems	HIV positive
Anemia	Epilepsy and/or seizures	Kidney disease
Arthritis	Headaches/migraines	Oral ulcers
Asthma	Heart disease	Rheumatic fever
Blood disorders	Heart murmur	Speech difficulties
Cancer	Heart valve condition	Surgery
Cold sores	Head or face injury	Thyroid condition
Diabetes	Hepatitis	Tuberculosis
Endocrine disorders	Herpes	Other (describe below)

Comments: _____

_____

_____

Does the patient require premedication prior to dental treatment? _____

Has the patient reached puberty (menstruation, voice change, hair...)? Yes No

How long ago? _____

Dental History

Date of last checkup: _____ Were the patient's teeth cleaned? Yes No

How often does the patient brush his/her teeth? _____

Has the patient ever sucked his/her thumb or fingers? Yes No

Is there a history of trauma to any teeth? Yes No Explain: _____

_____

Is there a history of pain in or around the ear?	Yes	No
Has there been a "pop" or "lock" of the jaw upon opening or closing?	Yes	No
Is there a history of grinding or clenching the teeth?	Yes	No
Is there a tongue thrusting habit or other functional problem?	Yes	No
Are there frequent sore throats or a history of tonsilitis?	Yes	No
Is there a history of mouth breathing or snoring?	Yes	No

What is the patient's or parent's primary concern - why are you here? _____

_____

_____

What is expected from orthodontic treatment? _____

_____

_____

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? _____

_____

_____

I have read and understand the above questions. I will not hold the orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

_____

Signature of adult patient or parent/guardian of child Date