ORTHODONTIC PATIENT INFORMATION

PATIENT'S NAME_____ AGE_____ BIRTH DATE_____ GENDER_____

HOME ADDRESS _____ HOME PHONE_____
STREET CITY ZIP

MOTHER'S NAME: _____ ☐ Check if home address is the same

WORK PHONE_____ CELL PHONE _____

EMAIL ADDRESS _____

HOME ADDRESS _____ HOME PHONE_____
(If different from patient) STREET CITY ZIP

FATHER'S NAME: _____ ☐ Check if home address is the same

WORK PHONE_____ CELL PHONE _____

EMAIL ADDRESS _____

HOME ADDRESS _____ HOME PHONE_____
(If different from patient) STREET CITY ZIP

PATIENT LIVING WITH: MOTHER _____ FATHER _____ BOTH _____ OTHER _____

PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? YES NO

IF YES, BY WHICH COMPANY? _____

NAME OF PERSON TO BE CONTACTED IF PATIENT CANNOT BE REACHED

NAME_____ RELATIONSHIP_____

ADDRESS_____ PHONE_____

FAMILY DENTIST_____ FAMILY PHYSICIAN_____

REFERRED BY _____

SIBLINGS _____ NONE

Sibling 1 Name _____ Date of Birth _____

Sibling 2 Name _____ Date of Birth _____

Sibling 3 Name _____ Date of Birth _____

Sibling 4 Name _____ Date of Birth _____

MEDICAL AND DENTAL HISTORY:

HEALTH: GOOD FAIR POOR CURRENTLY UNDER TREATMENT YES NO

SPECIFY: _____

CURRENTLY TAKING DRUGS OR MEDICATION? YES NO

SPECIFY: _____

HAS PATIENT BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST TWO YEARS OTHER THAN FOR ROUTINE EXAMINATION? YES NO

BIRTH DEFECTS YES NO

SPECIFY: _____

The following conditions are of interest to the orthodontist:

Has the patient ever had?

Aids	Endocrine Problems	Hepatitis
Asthma	Emotional Problems	Herpes
Anemia	Fainting	Hypertension (high blood pressure)
Bleeding Disorder	Gastrointestinal Disorder	Malignancies (Cancer)
Bone Disorder	Gum Disorders	Mouth Lesions
Diabetes	Heart Disease	Rheumatic Fever
Epilepsy	Heart Problems or Defects	Tuberculosis
	Head or Face Injury	Unintentional Weight Loss

Comments:_____

_____

Does the Patient:

1. Have allergies to Seasonal grasses _____ Food _____
   Drugs _____ Other _____
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually
   Comments:_____
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have difficulty chewing or swallowing? Yes No

Has the patient received medical treatment from an allergist or ear, nose and throat specialist? Yes No

I yes, When_____, By Whom_____

Tonsils removed? Yes No Adenoids removed? Yes No

Does the patient have pain or clicking in the jaw joint? Yes No

Has the patient had any trauma to the mouth or jaw joint? Yes No

Has the patient received or been requested to receive speech correction? Yes No

The following habits are of interest to the orthodontist. List information as it pertains to the patient.

Thumb sucking until age _____ Teeth grinding Yes No

Finger sucking until age _____ Tongue thrusting Yes No

Lip-biting or sucking Yes No Other habits Yes No

Has the patient had any unusual dental experiences? Yes No

Specify: _____

Has the patient had previous orthodontic consultation or treatment? Yes No

Date: _____ Dr. _____

If there any other medical, dental or surgical problems not covered above please describe _____

_____

ANY CHANGES IN THE PATIENT'S HEALTH WHILE UNDER OUR CARE SHOULD BE BROUGHT TO OUR ATTENTION.

PATIENT'S DENTAL HEALTH AND AWARENESS

Dental check-ups: Twice a year Once a year Only if urgent Never

Date of last dental check-up _____ Were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problem? Yes No

Patient's interest in orthodontics: Wants treatment Willing if necessary Unwilling but agrees Uncooperative

Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse

Sibling Physician Hygienist Friend Other _____

What is the reason for seeking an orthodontic consultation? _____

What is the primary problem? _____

Additional Comments _____

Signature of person completing this form:_____

Relationship to patient: _____ Today's date _____