Confidential Patient Information

HORSLEY ORTHODONTICS

Date _____

A B C

Patient's Name_____ Birthdate _____ Age _____
(Last) (First) (M.I) (Preferred Name)

Interests/Hobbies _____ Patient's Cell Phone_____ ☐ Male ☐ Female

Patient's Physical Address _____
(Street) (City) (State) (Zip)

Patient's Other Address _____
(Street) (City) (State) (Zip)

Dentist _____ Last Cleaning _____ Who referred you to our office? _____

List any immediate family members seen in our office: _____

Responsible Party Name_____ ☐ Married ☐ Divorced ☐ Single ☐ Widow(er) ☐ Other
(Last) (First) (Middle)

Birthdate _____ Employer _____Occupation _____ Years Employed _____

Residence _____ ☐ Own ☐ Rent ☐ Other
(Street) (City) (State) (Zip)

How long at this address _____ Previous Address (if less than 3 yrs) _____

Email _____ Cell # _____ SS# _____

Responsible Party Spouse_____ ☐ Wife ☐ Husband ☐ Other
(Last) (First) (Middle)

Birthdate _____ Employer _____Occupation _____ Years Employed _____

Email _____ Cell # _____ SS# _____

Dental Insurance _____ Policy Holder _____ Birthdate _____

Insurance Company Address _____ Phone # _____

Policy ID (or SS#) _____ Group # _____ Employer _____

Secondary Insurance _____ Policy Holder _____ Birthdate _____

Insurance Company Address _____ Phone # _____

Policy ID (or SS#) _____ Group # _____ Employer _____

I understand that (where appropriate) credit bureau reports may be obtained.

Responsible Party Signature _____

Name of nearest relative not living with you: _____Phone#_____

Address: _____Relation: _____

DENTAL AND ORTHODONTIC HISTORY

In your words, what is the orthodontic problem? _____

Have you had any previous orthodontic treatment or consultation? ☐ Yes ☐ No

If so, what was completed, and by whom? _____

Do you now have or have you experienced pain or discomfort in your jaw joint?	☐ Yes	☐ No
Do you grind your teeth?	☐ Yes	☐ No
Do you have any speech problems/tongue thrust?	☐ Yes	☐ No
Do you have or have you ever had any thumb or finger sucking habits?	☐ Yes	☐ No
Do you usually breath through your mouth while awake?	☐ Yes	☐ No
Have you ever experienced an adverse reaction during a medical or dental procedure?	☐ Yes	☐ No
Have you ever received serious trauma or injury to the teeth, face, jaws or head?	☐ Yes	☐ No
Do you have a family history of jaw size imbalance or missing, impacted, malformed or extra teeth?	☐ Yes	☐ No
Have you been treated for or diagnosed with any periodontal problems?	☐ Yes	☐ No

MEDICAL HISTORY

Please check if you have a history of any of the following:

Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Heart Disease or Heart Conditions
☐	☐	Allergies (latex, codeine, penicillin, metals, anesthetics, other)	☐	☐	Hepatitis
☐	☐	Artificial Joints or Valves	☐	☐	Osteoporosis/Osteopenia
☐	☐	Blood Pressure Problems	☐	☐	Rheumatoid or Arthritic Conditions
☐	☐	Cancer, tumor, radiation treatment or chemotherapy	☐	☐	Tuberculosis
☐	☐	Convulsions, Epilepsy or Fainting Spells	☐	☐	Anxiety
☐	☐	Diabetes	☐	☐	ADD/ADHD
☐	☐	Endocrine, Thyroid or Growth Problems	☐	☐	Autism/Sensory
☐	☐	Excessive bleeding, anemia or bleeding disorder	☐	☐	Learning/Processing Disability
☐	☐	Headaches	☐	☐	Other

If you answered yes to any of the above, please explain in more detail: _____

_____

Are you under the care of a physician for a specific condition not listed above? ☐ Yes ☐ No

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. I also understand that if there is any change to my, or the above named patient's dental or medical status, it is my responsibility to inform the doctor.

Signature: _____ Date: _____