



Confidential Patient Information Date \_\_\_\_\_ A B C

Patient's Name \_\_\_\_\_  
(Last) (First) (Middle) (Preferred Name)

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_  Male  Female

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Dentist \_\_\_\_\_ Last Cleaning \_\_\_\_\_ Favorite Sports/Hobbies \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Name** \_\_\_\_\_ Marital Status \_\_\_\_\_  
(Last) (First) (Middle)

Residence \_\_\_\_\_  Own  Rent  
(Street) (City) (State) (Zip)

Mailing Address \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
(Street) (City) (State) (Zip)

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

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ SS# \_\_\_\_\_

Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Email Address \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
(Last) (First) (Middle)

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ SS# \_\_\_\_\_

Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Years Employed \_\_\_\_\_

Primary 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 \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ Phone # \_\_\_\_\_

Complete Address \_\_\_\_\_ Relation \_\_\_\_\_

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

Signature (Parent's Signature if Patient is a minor) \_\_\_\_\_

## 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? \_\_\_\_\_

What other family member(s) have had orthodontics? \_\_\_\_\_

Were the results acceptable?  Yes  No

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

If yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

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

<u>Yes</u> <u>No</u>	<u>Yes</u> <u>No</u>
<input type="checkbox"/> <input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> <input type="checkbox"/> Heart Disease or Conditions
<input type="checkbox"/> <input type="checkbox"/> Allergies (latex, codeine, penicillin, metals, anesthetics, other)	<input type="checkbox"/> <input type="checkbox"/> Heart Murmur
<input type="checkbox"/> <input type="checkbox"/> Artificial Joints or Valves	<input type="checkbox"/> <input type="checkbox"/> Headaches
<input type="checkbox"/> <input type="checkbox"/> Asthma or Hay fever	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Blood Pressure Problems	<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> <input type="checkbox"/> Cancer, tumor, radiation treatment or chemotherapy	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis/Osteopenia
<input type="checkbox"/> <input type="checkbox"/> Convulsions, Epilepsy or Fainting Spells	<input type="checkbox"/> <input type="checkbox"/> Rheumatic/Scarlet Fever
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Rheumatoid or Arthritic Conditions
<input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> <input type="checkbox"/> Tonsillitis
<input type="checkbox"/> <input type="checkbox"/> Endocrine, Thyroid or Growth Problems	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Excessive bleeding, anemia or bleeding disorder	

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

If yes, please describe: \_\_\_\_\_

Are you taking any of medications? (including bisphosphonates, anti-inflammatories and steroids)  Yes  No

If yes, please list medication and what it's taken for: \_\_\_\_\_

\_\_\_\_\_

## 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: \_\_\_\_\_