ORTHODONTICS
FOR CHILDREN AND ADULTS
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Patient Information Form

Date: _____

Personal Information

Patient's Title: Mr. Mrs. Ms. Dr. **First Name**: _____ **MI**: _____ **Last Name**: _____

Preferred Name: _____ Age: _____ Birth Date: _____ Gender: F M

Home Address: _____ Phone #: _____

Occupation: _____ Employer: _____

Business Address: _____

Email: _____ Best Daytime Phone #: _____

Hobbies / Interests: _____

Why are you seeking an orthodontic evaluation? _____

Has anyone in the family been treated in this office before? _____

Whom may we thank for referring you? _____

Medical History

Physician Name: _____ Date of last physical exam: _____

Address: _____ Phone #: _____

For the following questions, please mark Yes, No, or Don't Know. If yes, please describe. All information will be retained for our records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

	Yes	No	Don't Know
Are you in good health?	☐	☐	☐
Have you had any serious illnesses, operations, or hospitalizations?	☐	☐	☐
Are you taking any medications at this time?	☐	☐	☐
Have you shown any allergies or reactions to medications, foods, or other substances?	☐	☐	☐
Do you use alcohol, tobacco, or controlled substances (drugs)?	☐	☐	☐
Do you have or have you ever had any of the following: ***(Please check all that apply)***	☐	☐	☐

- ☐ Vision / hearing / taste / speech difficulties
- ☐ Ear / nose / throat problems
- ☐ Migraine headaches
- ☐ Fainting episodes / seizures / epilepsy
- ☐ Hepatitis / liver / stomach / kidney problems
- ☐ Polio / mononucleosis / tuberculosis / pneumonia
- ☐ Asthma / bronchitis / emphysema
- ☐ Chest pain / shortness of breath
- ☐ Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, heart defects, heart murmur, rheumatic heart disease)
- ☐ Hives / skin rash / skin disorder
- ☐ Arthritis / joint / bone disorders
- ☐ Abnormal bleeding / bruising / anemia
- ☐ High / low blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Endocrine or thyroid problems
- ☐ Birth defects
- ☐ Problems of the immune system / autoimmune disease
- ☐ Mental health disturbance / depression
- ☐ Eating disorder
- ☐ Learning disabilities
- ☐ Emotional disabilities
- ☐ Sexually transmitted disease
- ☐ HIV / AIDS
- ☐ Orthopedic total joint replacement
- ☐ Artificial (prosthetic) heart valve
- ☐ Previous infective endocarditis
- ☐ Damaged valves in transplanted heart
- ☐ Congenital heart disease (CHD)
- ☐ Unrepaired, cyanotic CHD
- ☐ Repaired (completely) in last 6 mos
- ☐ Repaired CHD with residual defects
- ☐ Use of bisphosphonates such as alendronate (Fosamax®), risedronate (Actonel®), or been treated with intravenous bisphosphonates?

Has a physician or dentist recommended that you take antibiotics prior to dental treatment?	☐	☐	☐
Are there any other medical conditions that we should be aware of?	☐	☐	☐

Females:

Are you pregnant or nursing?	☐	☐	☐

If you have marked Yes for any of the above, please provide details below:

_____

_____

_____

Dental History

Dentist Name: _____

Address: _____ Phone #: _____

Date of last exam / cleaning: _____ Any remaining treatment required: _____

For the following questions, please mark Yes, No, or Don't Know. If yes, please describe. All information will be retained for our records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

	Yes	No	Don't Know
Did you start teething very early or very late?	☐	☐	☐
Are you missing any teeth or have any extra teeth?	☐	☐	☐
Have you had any injury to your teeth or jaws?	☐	☐	☐
Did you have any thumb / finger or pacifier sucking habit?	☐	☐	☐
Are you aware of any clenching or grinding of your teeth?	☐	☐	☐
Are your teeth sensitive to hot, cold, or pressure?	☐	☐	☐
Do your gums bleed during brushing or flossing?	☐	☐	☐
Have you ever had a periodontal evaluation or treatment?	☐	☐	☐
Have you ever had an orthodontic evaluation?	☐	☐	☐
Have you ever had any orthodontic treatment?	☐	☐	☐
Is there any family history of missing or impacted teeth, or orthognathic (jaw) surgery?	☐	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐	☐
Do you have difficulty opening or closing your mouth?	☐	☐	☐
Do you breathe mostly with your mouth?	☐	☐	☐
Have you had tonsils or adenoids removed?	☐	☐	☐

If you have marked Yes for any of the above, please provide details below:

_____

_____

_____

Responsible Party Information

First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ SS #: _____

Billing Address: _____

Relationship to patient: _____ Best Daytime Phone #: _____

Dental Insurance Information

Subscriber First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ SS #: _____

Relationship to patient: _____

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

Dental Insurance Company Name: _____

Dental Insurance Company Address: _____

Dental Insurance Company Phone #: _____

Policy #: _____ Group #: _____ ID #: _____

If you have dual coverage, please provide information for the second dental insurance policy:

Subscriber First Name: _____ MI: _____ Last Name: _____

Birth Date: _____ SS #: _____

Relationship to patient: _____

Employer Name: _____ Employer Phone #: _____

Employer Address: _____

Dental Insurance Company Name: _____

Dental Insurance Company Address: _____

Dental Insurance Company Phone #: _____

Policy #: _____ Group #: _____ ID #: _____

Please bring your dental insurance card to your appointment, or provide us with a copy of the front and back of the card.

I understand that the information I have given is correct to the best of my knowledge, and that it will be held in the strictest of confidence. **Information provided may be used to obtain credit history in order to provide the best possible payment options**.

I understand that it is my responsibility to inform this office of any changes in medical / dental status or personal information.

Signature: _____

Relationship to Patient: _____ Date: _____