ORTHODONTICS
For Children and Adults

MEDICAL/DENTAL HISTORY

Patient's Name: _____

Dentist's Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Please indicate if the patient has any of the following conditions:

☐Yes ☐No Currently under any medical treatment. Please describe _____

☐Yes ☐No Pain, clicking, and/or popping noises in the jaw

☐Yes ☐No Clenching or grinding of teeth

☐Yes ☐No Frequent headaches. How often? _____

☐Yes ☐No Ear problems (Aches, ringing, dizziness, fullness)

☐Yes ☐No Difficulty breathing through the nose

☐Yes ☐No Habits such as nail biting, finger or thumb sucking, lip or cheek biting

☐Yes ☐No Speech problems, or undergoing speech therapy

☐Yes ☐No Tonsils and/or adenoids removed

☐Yes ☐No Has there been any history of: ☐Joint swelling ☐Asthma ☐TB ☐HIV/AIDS ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic Fever ☐Thyroid Disorder ☐Other major illnesses _____

☐Yes ☐No Bleeding problems _____

☐Yes ☐No Fainting or dizzy spells

☐Yes ☐No Allergies (Sulfa, Penicillin, Novocain, Latex, etc.) _____

☐Yes ☐No Currently taking any medication. Please list: _____

☐Yes ☐No Heart condition. Do you pre-medicate? ☐Yes ☐No Cardiologist: _____

☐Yes ☐No Sleep apnea

☐Yes ☐No Smoke or chew tobacco

☐Yes ☐No Any injuries to the teeth. Please describe _____

☐Yes ☐No Any permanent teeth extracted

☐Yes ☐No Have we treated any other family members? Names: _____

☐Yes ☐No Are there any other medical conditions or history that we should know about? Please describe:

_____

To the best of my knowledge, all of the preceding answers are true and correct. If there is ever any change in the medical history or medications, I will inform the doctor at my next appointment without fail.

Responsible Party's Signature: _____ Date: _____

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date _____

Patient's Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *Zip*

Home Phone _____ Birth Date _____

If patient is minor, please give parent or guardian's name _____

Patient: _____ Responsible Party: _____
Email Address *Email Address*

RESPONSIBLE PARTY INFORMATION

Name _____
Last *First* *Middle* *Marital Status*

Residence _____
Street *City* *State* *Zip*

Mailing Address _____
Street *City* *State* *Zip*

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street *City* *State* *Zip*

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last *First* *Middle*

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes ☐ No ☐ If Yes, please continue: _____
Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group # _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Complete Address _____
Phone _____ Relationship to Patient _____

Signature (Parent's signature, if minor) _____ Date _____
I understand that where appropriate, credit bureau reports may be obtained.