PATIENT INFORMATION (CONFIDENTIAL))

Patient's name_____ Preferred name _____**Age** ____ DOB_____ Gender_____

Address_____City_____ Zip_____

Home phone_____ Cell phone_____ Email_____

School/ Employer_____ Whom may we thank for referring you? _____

How would you like to be contacted by our office? Phone ___ Email ___ Text message ___

Family Dentist _____ Family Physician _____

What do you see as the main orthodontic problem(s)? _____

What are your expectations for orthodontic treatment? _____

How do you feel about the possibility of wearing braces? _____

RESPONSIBLE PARTY INFORMATION

Mother/Wife's Name _____ **Employer** _____

Cell phone _____ Email address_____

Address if different than above_____

Father/Husband's Name_____**Employer** _____

Cell phone _____ Email address _____

Address if different than above_____

DENTAL INSURANCE INFORMATION

PRIMARY ***DENTAL*** INSURANCE

Insured's name _____

Insurance Company _____

ID/ SS# _____ Group # _____

DOB _____ Employer _____

Insurance Address _____

Insurance phone #_____

SECONDARY ***DENTAL*** INSURANCE

Insured's name_____

Insurance Company _____

ID/ SS# _____ Group # _____

DOB _____ Employer _____

Insurance Address _____

Insurance phone # _____

DENTAL HISTORY

Has the patient ever experienced any of the following?

Y N Previous orthodontic treatment or evaluation
Y N Injuries to the face, mouth, teeth or chin
Y N Been informed of any missing or extra teeth
Y N Pain/tenderness/popping in the jaw joint
Y N Speech problems
Y N Wear a dental device/splint
Y N Been diagnosed/ treated for Periodontal Disease : describe _____

HABITS

Does/did the patient have any of the following habits?

Y N Clenching teeth
Y N Grinding teeth
Y N Lip sucking/ Biting
Y N Mouth breathing
Y N Current thumb/Finger Sucking
Y N Past thumb/Finger Sucking
Y N Smoking/Chewing Tobacco
Y N Tongue thrust

ALLERGIES

Is the patient allergic to any of the following?

Y N Aspirin/ Ibuprofen
Y N Metal or plastics
Y N Latex
Y N Penicillin or any related cillin drug
Y N Sulfa drugs
Y N Dairy
Y N Other _____
Y N Does the patient require an Epi- Pen?

**** if yes, we ask it is with the patient at each appointment****

MEDICAL HISTORY

Does patient have/ had any of the following?

Y N Heart trouble/Murmurs
Y N Rheumatic fever
Y N Artificial heart valves
Y N Artificial Joints
Y N Diabetes: Type _____
Y N Kidney Disease
Y N Bleeding Disorders
Y N Cold Sores/Canker Sores
Y N Females: Current Pregnancy
Y N Tuberculosis
Y N Ear, nose or throat problems
Y N Asthma
Y N Repeated headaches/Facial pain
Y N AIDS/HIV/STDs
Y N Respiratory infections
Y N Hearing impairment
Y N Osteoporosis/Bone loss
Y N High blood pressure
Y N Hepatitis: Type _____

Please describe any medical problems:

Please list all medications the patient is taking:

I hereby certify that I have read and understand the above information and acknowledge the information is correct and true

X_____ _____
Signature of patient (or parent/ guardian if minor) Date

I agree that the dental practice may communicate electronically with me at the email address above. **I am aware that there is some level of risk that third parties might be able to read unencrypted emails.** I am responsible for providing any updates to my email address. I can withdraw my consent to electronic communications by phone.

X_____ _____
Signature of patient (or parent/ guardian if minor) Date