

**Thomas J. Melcher, D.D.S., M.S., P.C.**

*New Patient Information*

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Gender: Male Female

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ School/Employer \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Mother/Wife's Work Phone \_\_\_\_\_ Father/Husband's Work Phone \_\_\_\_\_

Father/Husband's Name \_\_\_\_\_ Employer \_\_\_\_\_

Mother/Wife's Name \_\_\_\_\_ Employer \_\_\_\_\_

Family Dentist \_\_\_\_\_ City \_\_\_\_\_

Family Physician \_\_\_\_\_ City \_\_\_\_\_

How do you prefer to be contacted by our office? \_\_\_\_\_ Phone call \_\_\_\_\_ Text Message \_\_\_\_\_ Email

Whom may we thank for referring you? \_\_\_\_\_

Person(s) Responsible for this Account \_\_\_\_\_

**DENTAL INSURANCE INFORMATION** Person Who Carries Insurance \_\_\_\_\_

Name of Dental Insurance \_\_\_\_\_ I.D.#/S.S.# \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insured's Date of Birth \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Employer Name \_\_\_\_\_

In your own words, what do you see as the main orthodontic problem(s)? \_\_\_\_\_

What are your expectations from orthodontic treatment? \_\_\_\_\_

How do you feel about the possibility of wearing braces? \_\_\_\_\_

**MEDICAL & DENTAL HISTORY**

Please describe any medical problems: \_\_\_\_\_

Please list any current medications: \_\_\_\_\_

Please describe any allergies you have (medicines, food, latex, or metal allergies) \_\_\_\_\_

**Do you have or have you had (please circle):**

<b>Heart Trouble/Murmurs</b>	<b>Yes</b>	<b>No</b>	<b>Females: Current Pregnancy?</b>	<b>Yes</b>	<b>No</b>
<b>Rheumatic Fever</b>	<b>Yes</b>	<b>No</b>	<b>Tuberculosis/Infectious Diseases</b>	<b>Yes</b>	<b>No</b>
<b>Artificial Heart Valves</b>	<b>Yes</b>	<b>No</b>	<b>Arthritis/Joint Disorders</b>	<b>Yes</b>	<b>No</b>
<b>Artificial Joints</b>	<b>Yes</b>	<b>No</b>	<b>Ear, Nose or Throat Problems</b>	<b>Yes</b>	<b>No</b>
<b>Diabetes</b>	<b>Yes</b>	<b>No</b>	<b>Hayfever/Asthma/Sinus Problems</b>	<b>Yes</b>	<b>No</b>
<b>Kidney Diseases or Infections</b>	<b>Yes</b>	<b>No</b>	<b>Convulsions or Seizures</b>	<b>Yes</b>	<b>No</b>
<b>High Blood Pressure</b>	<b>Yes</b>	<b>No</b>	<b>Repeated Headaches/Facial Pain</b>	<b>Yes</b>	<b>No</b>
<b>Hepatitis: Type ____</b>	<b>Yes</b>	<b>No</b>	<b>Repeated Sore Throats or Respiratory Infections</b>	<b>Yes</b>	<b>No</b>
<b>Bleeding Disorders</b>	<b>Yes</b>	<b>No</b>	<b>Smoking/Chewing Tobacco</b>	<b>Yes</b>	<b>No</b>
<b>Cold Sores, Canker Sores</b>	<b>Yes</b>	<b>No</b>	<b>AIDS/HIV/STDs</b>	<b>Yes</b>	<b>No</b>

**Have you been diagnosed or treated for periodontal (gum) disease?** **Yes** **No**

**Describe:** \_\_\_\_\_

**Do you have any clicking, pain or locking in your jaw joints?** **Yes** **No**

**Describe:** \_\_\_\_\_

**Have you ever had any major trauma to your jaws?** **Yes** **No**

**Describe:** \_\_\_\_\_

**Any finger or thumb-sucking habits?** **Yes** **No**

**Do you grind or clench your teeth?** **Yes** **No**

**I hereby certify that all of the above information is correct and true.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**MEDICAL HISTORY UPDATES**

<b>Date</b>	<b>Changes</b>	<b>Initials</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____