



**PATIENT INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ PREFERRED NAME \_\_\_\_\_  
 BIRTH DATE \_\_\_\_\_ SEX:  M  F  
 MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 HAS ANY FAMILY MEMBER RECEIVED TREATMENT AT OUR OFFICE?  YES  NO If yes, who? \_\_\_\_\_  
 DENTIST \_\_\_\_\_ WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
 MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOW LONG AT THIS ADDRESS \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ EMAIL \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 SOCIAL SECURITY NUMBER \_\_\_\_\_ CURRENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 SPOUSE NAME \_\_\_\_\_ SPOUSE SOCIAL SECURITY NUMBER \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
 SPOUSE'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
 SPOUSE'S WORK PHONE \_\_\_\_\_ IF NECESSARY, MAY WE CALL YOU OR YOUR SPOUSE AT WORK?  YES  NO  
 EMAIL \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

INS. CO. NAME (PRIMARY) _____	INS. CO. NAME (SECONDARY) _____
INS. CO. ADDRESS _____ _____	INS. CO. ADDRESS _____ _____
INSURANCE COMPANY PHONE NUMBER _____	INSURANCE COMPANY PHONE NUMBER _____
GROUP NUMBER _____	GROUP NUMBER _____
POLICY HOLDER NAME _____	POLICY HOLDER NAME _____
POLICY HOLDER SOC. SEC. NO. _____	POLICY HOLDER SOC. SEC. NO. _____
POLICY HOLDER BIRTH DATE _____	POLICY HOLDER BIRTH DATE _____
POLICY HOLDER EMPLOYER _____	POLICY HOLDER EMPLOYER _____

**INITIAL EXAM INFORMATION**

WHAT IS YOUR CHIEF CONCERN IN SEEKING ORTHODONTIC CARE? \_\_\_\_\_  
 WHAT IS YOUR DENTIST'S MAIN CONCERN REGARDING YOUR BITE? \_\_\_\_\_  
 IN AN EFFORT TO AVOID RECORDS DUPLICATION – HAS ANOTHER ORTHODONTIST BEEN CONSULTED PREVIOUSLY? \_\_\_\_\_

The policy in our office is that the parent who requests treatment is responsible for all fees of services rendered.  
 When appropriate, credit information will be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**SIGNATURE ON FILE**

By signing below: I authorize the use of this form and its information for all my insurance submissions.  
 I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.  
 I authorize insurance payment directly to this office.  
 I authorize the use of a copy of this form which can be used in place of the original.  
 I understand where appropriate a credit report may be obtained.

Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME OF YOUR PHYSICIAN: \_\_\_\_\_

PHYSICIAN PHONE: \_\_\_\_\_

### PATIENT MEDICAL PROFILE

- Yes  No, please explain 1. Are you in good health?  
 Yes  No, please explain 2. Do you eat a well-balanced diet?

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY : Please check Yes or No for each condition: (if yes, please explain)

<input type="checkbox"/> Yes <input type="checkbox"/> No AIDS or HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Oral Ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Allergies	<input type="checkbox"/> chemo <input type="checkbox"/> radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory problems
<input type="checkbox"/> acrylic	<input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular condition	<input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever
<input type="checkbox"/> aspirin	<input type="checkbox"/> angina <input type="checkbox"/> heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No Sensory Conditions
<input type="checkbox"/> ibuprofen	<input type="checkbox"/> heart defect	<input type="checkbox"/> hearing <input type="checkbox"/> tasting
<input type="checkbox"/> latex	<input type="checkbox"/> heart murmur	<input type="checkbox"/> vision <input type="checkbox"/> other
<input type="checkbox"/> metals	<input type="checkbox"/> stroke	_____
<input type="checkbox"/> nickel	<input type="checkbox"/> other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Speech Condition
<input type="checkbox"/> vinyl	<input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency	Explain _____
<input type="checkbox"/> other	<input type="checkbox"/> Yes <input type="checkbox"/> No Eating Disorder	_____
_____	<input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No Stomach ulcers
<input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis (Rheumatism)	<input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No Tonsils/Adenoids
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Headaches/Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Condition
<input type="checkbox"/> Yes <input type="checkbox"/> No Attention Deficit Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis
<input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No Immune System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have any other
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement	medical conditions that we
<input type="checkbox"/> anemia <input type="checkbox"/> bruise easily	<input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disorders	should know about?
<input type="checkbox"/> excessive bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia	
<input type="checkbox"/> other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health Condition	
<input type="checkbox"/> Yes <input type="checkbox"/> No Blood pressure condition	<input type="checkbox"/> Yes <input type="checkbox"/> No Neurological Disorder	
<input type="checkbox"/> high <input type="checkbox"/> low	<input type="checkbox"/> epilepsy <input type="checkbox"/> fainting	
	<input type="checkbox"/> seizures	
	<input type="checkbox"/> other _____	

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Do you take prescription medication, over the counter medication, nutritional supplements, or herbal medication?  
Please list all medications:  
Medication \_\_\_\_\_ Taken For \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes  No Are you currently being treated by another health professional? Please explain below  
 Yes  No Are you pregnant or do you think you may be pregnant?  
 Yes  No Do you require pre-medication for dental procedures? Please explain below  
 Yes  No Is there any other health information about you that we should know about?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DENTIST'S NAME \_\_\_\_\_ DATE OF LAST DENTAL EXAM: \_\_\_\_\_

## DENTAL GENETICS

### YOUR HISTORY

- Yes  No 1. Do you have missing teeth?
- Yes  No 2. Do you have extra teeth?
- Yes  No 3. Did you have slowly erupting teeth?
- Yes  No 4. Did you have unerupted teeth?
- Yes  No 5. Do you have thin gum tissue?
- Yes  No 6. Do your teeth have short roots?
- Yes  No 7. Is there anything else about your dental history that we should know about?

### FAMILY HISTORY

- Yes  No 1. Is there a family history of missing teeth?
- Yes  No 2. Is there a family history of extra teeth?
- Yes  No 3. Is there a family history of slowly erupting teeth?
- Yes  No 4. Is there a family history of unerupted teeth?
- Yes  No 5. Is there a family history of gum tissue treatment?
- Yes  No 6. Is there a family history of short roots?
- Yes  No 7. Is there a family history of an underdeveloped lower jaw?
- Yes  No 8. Is there a family history of a strong lower jaw?

## DENTAL HISTORY

- Yes  No, please explain 1. Are you in good dental health?
- Yes  No, please explain 2. Do you brush and floss regularly?
- Yes  No, please explain 3. Are your dental x-rays up to date?
- Yes  No, please explain 4. Have you seen the dentist in the past six months?
- No  Yes, please explain 5. Have you experienced any unusual dental problems?

Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check Yes or No. If the answer is yes, please list question number and explain.

<p><b>Now or in the past have you had:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes <input type="checkbox"/> No 1. Any history of injured teeth?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 2. Injury to the head, neck, or jaws?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 3. Tooth sensitivity to hot or cold?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 4. History of dental problems?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 5. Periodontal or "gum tissue" problems?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 6. Bleeding gums when brushing?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 7. Food impaction between teeth?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 8. Frequent canker sores or cold sores?</li></ul> <p><b>Jaw Joint History</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes <input type="checkbox"/> No 9. History of jaw joint pain?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 10. History of jaw joint clicking or locking?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 11. History of facial muscle pain?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 12. Difficulty chewing, opening, or closing?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 13. History of treatment for TMD or TMJ?</li></ul>	<p><b>Functional/Habit History</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes <input type="checkbox"/> No 14. History of thumb or finger habit?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 15. History of tongue thrusting?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 16. History of abnormal swallowing?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 17. Difficulty eating?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 18. History of mouthbreathing?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 19. History of snoring?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 20. History of tooth grinding?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 21. History of jaw clenching?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 22. History of speech difficulty?</li><li><input type="checkbox"/> Yes <input type="checkbox"/> No 23. Any history of speech therapy?</li></ul> <p><b>Please explain if yes</b> _____ _____ _____</p>
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Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns please indicate what you would like orthodontics to accomplish for your family:

- Enhance esthetics and appearance
- Increase self confidence
- Create facial balance
- Enhance overall dental health
- Improve function, comfort, and stability
- Avoid future problems

