

PATIENT INFORMATION

Last Name _____ First Name _____ Preferred Name _____
Birth Date ____/____/____ Age ____ Sex M[_] F[_] School _____ Grade ____
Address _____ City _____ State _____ Zip _____
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____
Activities/Hobbies _____ Ages of Siblings (____) (____) (____) (____)
Has any family member received treatment at our office? Yes[_] No[_] if yes, who? _____
Dentist _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Last Name _____ First Name _____ Birth Date ____/____/____ Marital Status _____
Address _____ City _____ State _____ Zip _____
Time at this address _____ Relationship to patient _____ Email _____
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____
Current Employer _____ Occupation _____
Spouse's Name _____ Birth Date ____/____/____ Relationship to patient _____
Current Employer _____ Occupation _____
Work Phone (____) ____ - ____ May we call you/spouse at work? Yes[_] No[_] Email _____

If a parent (responsible party) is not living with the patient, please complete the following

Last Name _____ First Name _____ Birth Date ____/____/____
Address _____ City _____ State _____ Zip _____
Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

ORTHODONTIC INSURANCE INFORMATION

Insurance Company (Primary) _____ Insurance Company (Secondary) _____
Address _____ Address _____
Phone Number (____) ____ - ____ 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 the patient's bite? _____
In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes[_] No[_]

Our policy is that the parent/guardian who requests treatment is responsible for all fees for 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 ____/____/____

MEDICAL HISTORY

Name of patient's physician _____ Physician's Phone (____) _____ - _____

please check yes or no for each condition (if yes, please explain)

<i>Allergies</i>		Yes [] No [] AIDS or HIV positive	Yes [] No [] Oral ulcers
Yes [] No [] Acrylic		Yes [] No [] Cancer	Yes [] No [] Respiratory problems
Yes [] No [] Aspirin		Yes [] No [] Chemo	Yes [] No [] Rheumatic fever
Yes [] No [] Ibuprofen		Yes [] No [] Radiation	
Yes [] No [] Latex			<i>Sensory conditions</i>
Yes [] No [] Metals			Yes [] No [] Hearing
Yes [] No [] Nickel		<i>Cardiovascular conditions</i>	Yes [] No [] Tasting
Yes [] No [] Vinyl		Yes [] No [] Angina	Yes [] No [] Vision
Yes [] No [] Other _____		Yes [] No [] Heart attack	Yes [] No [] Other _____
		Yes [] No [] Heart defect	
Yes [] No [] Arthritis (Rheumatism)		Yes [] No [] Heart murmur	Yes [] No [] Speech condition (if yes, explain)
Yes [] No [] Asthma		Yes [] No [] Stroke	_____
Yes [] No [] Attention Deficit Disorder		Yes [] No [] Other _____	
			Yes [] No [] Tonsils/adenoids
<i>Blood disorders</i>		<i>Neurological disorders</i>	Yes [] No [] Tuberculosis
Yes [] No [] Anemia		Yes [] No [] Epilepsy	
Yes [] No [] Bruise easily		Yes [] No [] Fainting	Yes [] No [] Does your child have any other
Yes [] No [] Excessive bleeding		Yes [] No [] Seizures	medical conditions that we should
Yes [] No [] Other _____		Yes [] No [] Other _____	know about?
			If yes, please explain _____
<i>Blood pressure conditions</i>		Yes [] No [] Eating disorder	_____
Yes [] No [] high		Yes [] No [] Headaches/migraines	_____
Yes [] No [] low		Yes [] No [] Hepatitis	_____
		Yes [] No [] Immune system disorder	_____
		Yes [] No [] Kidney disorders	_____

MEDICATION HISTORY

Yes [] No [] Is your child taking any prescription medication, over the counter medication, nutritional supplements, or herbal medication?

Please list all medications...

Medication	Taken for
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DENTAL HISTORY

- Yes [] No [] Does the patient have missing teeth?
- Yes [] No [] Does the patient have extra teeth?
- Yes [] No [] Does the patient have slowly erupting teeth?
- Yes [] No [] Does the patient have unerupted teeth?
- Yes [] No [] Does the patient have thin gum tissue?
- Yes [] No [] Does the patient brush and floss regularly?
- Yes [] No [] Is the patient in good dental health?
- Yes [] No [] Are the patient's x-rays and fluoride treatments up to date?
- Yes [] No [] Has the patient seen the dentist in the past six months?
- Yes [] No [] Is the patient cooperative/ helpful during dental treatment?
- Yes [] No [] Has the patient experienced any unusual dental problems?
- Yes [] No [] Is there anything else about your child's dental history that we should know about?

If yes to any above, please explain _____

Now or in the past has your child had...

- Yes [] No [] ...any history of injured teeth?
- Yes [] No [] ...injury to the head, neck, or jaws?
- Yes [] No [] ...tooth sensitivity to hot or cold?
- Yes [] No [] ...history of dental problems?
- Yes [] No [] ...periodontal or "gum tissue" problems?
- Yes [] No [] ...bleeding gums when brushing?
- Yes [] No [] ...food impaction between teeth?
- Yes [] No [] ...frequent canker sores or cold sores?

Jaw joint history

- Yes [] No [] ...history of jaw joint pain?
- Yes [] No [] ...history of jaw joint clicking or locking?
- Yes [] No [] ...history of facial muscle pain
- Yes [] No [] ...difficulty chewing, opening, or closing?
- Yes [] No [] ...history of treatment for TMD or TMJ?

Functional/habit history

- Yes [] No [] ...history of thumb or finger habit?
- Yes [] No [] ...history of tongue thrusting?
- Yes [] No [] ...history of abnormal swallowing?
- Yes [] No [] ...difficulty eating?
- Yes [] No [] ...history of mouthbreathing?
- Yes [] No [] ...history of snoring?
- Yes [] No [] ...history of tooth grinding?
- Yes [] No [] ...history of jaw clenching?
- Yes [] No [] ...history of speech difficulty?
- Yes [] No [] ...any history of speech therapy?

If yes to any above, please explain _____

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 aesthetics and appearance
- [] Improve function, comfort, and stability
- [] Enhance overall dental health
- [] Create facial balance
- [] Increase self confidence
- [] Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

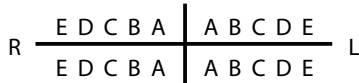
Signature _____ **On behalf of** _____ **Date** ____/____/_____
(responsible party) (patient)

MEDICAL / DENTAL HISTORY UPDATE

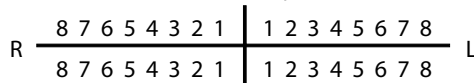
Date	Medical/dental status change?	Signature	Change in status
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		

FOR OFFICE USE ONLY

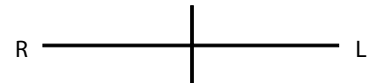
Deciduous teeth present



Permanent teeth present



Crossbites



Molar and Canine classification

	Right side		Left side	
	Molar	Canine	Molar	Canine
Class I				
End to End II				
Class II				
Class III				

Skeletal

	R	L
Class I	[]	[]
Class II	[]	[]
Class III	[]	[]
Upper midline	[]	[]
Lower midline	[]	[]

	Mild	Moderate	Severe
Upper Crowding	[]	[]	[]
Lower Crowding	[]	[]	[]
Overbite	_____	_____	_____ %
Frenum	Inv. []	Not Inv. []	
Midline Diastema	_____	_____	_____ mm
Overjet	_____	_____	_____ mm

Date	Recommendation