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ORTHODONTIC PATIENT INFORMATION

PLEASE FILL OUT BOTH SIDES COMPLETELY

Welcome to our office.

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, is important for our records and your health, is confidential. Please circle the appropriate response where indicated. **Thank You**

Patient's Name _____ S.S. # _____ Age _____ Birthdate _____ Sex _____
Employer _____ Occupation _____ Email _____
Home Address _____ Home Phone _____
City _____ State _____ Zip _____ Business Phone _____

IF ADULT, PLEASE DISREGARD PARENTS NAMES

Father's Name _____ S.S. # _____ Home Phone _____
Employer _____ Occupation _____ Business Phone _____
Mother's Name _____ S.S. # _____ Home Phone _____
Employer _____ Occupation _____ Business Phone _____

Person responsible for account: _____
Address _____ City _____ State _____ Zip _____

Is patient covered by insurance for orthodontic treatment? Yes No

If yes, by which company? _____ Insurance Phone # _____ ID # _____

Subscriber Name _____ Birthdate _____ Employer _____

Emergency Contact (Nearest relative not living with you)

Name _____ Relationship _____

Address _____ Phone _____

Family Dentist _____ Family Physician _____ Referred by _____

Other family members with similar orthodontic condition?

Father Mother Brother Sister Other Specify _____

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment: Yes No

Specify: _____

Present Drugs or Medication: Yes No

Specify: _____

Has patient been under care of a physician during the past two years other than for routine examination? Yes No

Birth Defects Yes No

Specify: _____

The following conditions are of interest to the orthodontist.

Has the patient ever had:

- Asthma
- Anemia
- Blood Disease
- Bone Disorders
- AIDS/HIV - Infection
- Diabetes
- Epilepsy
- Endocrine Problems
- Emotional Problems
- Heart Disease
- Hearing Disorder
- Head of Face Injury
- Rheumatic Fever

Comments:

Does the patient:

1. Have allergies to: Metals _____ Food _____ Drugs _____
2. Breathe through mouth? Seldom Sometimes Usually Comments _____
3. Have frequent sore throat or tonsillitis? Yes No
4. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose, throat specialist? Yes No

If Yes: When: _____ By Whom: _____

Tonsils removed: _____ Adenoids removed: _____

Does the patient have pain or clicking in jaw point? Yes No

Have any teeth been injured due to accidents or blow to the mouth? Yes No

Has the patient received or been requested to receive speech correction? Yes No

Has the patient received or requested to receive treatment to TMJ? Yes No

Thumb sucking until age _____ Grinding teeth Yes No

Finger sucking until age _____ Tongue thrusting Yes No

Lip-biting or sucking? Yes No Other habits Yes No

Has the patient had any unusual dental experiences? Yes No

Specify: _____

Has the patient had previous orthodontic consultation or treatment? Yes No

Date: _____ Dr.: _____

Are there any other medical, dental or surgical problems not covered above? Yes No

If yes, explain: _____

PATIENT'S ATTITUDE TOWARD ORTHODONTIC TREATMENT:

Is the patient aware of any orthodontic problem? Yes No

Patient's interest in orthodontic treatment:

Patient wants treatment Unwilling but agrees Uncooperative

Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse Sibling
Physician Friend Other: (specify) _____

Why did the patient seek this consultation? _____

What is the primary problem? _____

Signature of individual completing this form: _____

Relationship to patient: _____ Date: _____