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# ORTHODONTIC PATIENT INFORMATION

PLEASE FILL OUT BOTH SIDES COMPLETELY

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_____

Gender Identifies As: ☐ Female ☐ Male ☐ Non-Binary Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other

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 ______________

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

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:_________________________