Patient Information

Date:_____

Patient's full name: _____ Prefers to be called: _____

Patient's Address: _____ Home Phone: _____

_____ Cell Phone: _____

Patient's Birthday: _____ Email: _____

□ Male □ Female □ Single □ Married □ Divorced

Patient's Dentist: _____ Date Last Visited: _____

Whom may we thank for referring you? _____

Name(s) and age(s) of children:_____

Other family members seen by us: _____

Your Employer: _____ Social Security Number: _____

Your Occupation: _____ Work Phone: _____

Spouse's Name: _____ Email: _____

Spouse's Employer: _____ Work Phone: _____

Spouse's Occupation: _____ Cell Phone: _____

Emergency Contact (if different than spouse): _____ Phone: _____

Primary Dental Insurance Information

Insured's Name: _____ Insured's SSN: _____

Insured's Employer: _____ Insured's Birthday: _____

Insurance Company Name: _____ Phone #: _____

Insurance Company Address: _____

Group Number (Plan, local or policy No.): _____

Relationship to patient: _____

Health History

Medical History

(please check if patient has, or has had…)

□ AIDS/HIV Infection
□ Alcoholism
□ Angina/Chest pain
□ Arthritis
□ Asthma/Breathing problems
□ Blood disease
□ Cancer/Tumors
□ Cold sores
□ Diabetes
□ Drug addiction/use
□ Emotional problems
□ Endocrine problems
□ Epilepsy
□ Excessive bleeding
□ Heart problems
□ Hepatitis A, B or C
□ High/Low blood pressure
□ Intestinal Problems
□ Joint swelling
□ Kidney problems
□ Liver problems
□ Lung disease
□ Rheumatic Fever
□ Thyroid problems
□ Tonsils removed
□ Tuberculosis

Please explain all checked responses: _____

List any allergies: _____

List any medications: _____

Have you ever been told you need to pre-medicate before a dental appointment? _____

Dental History

(please check if patient has, or has had…)

□ Any injuries to face, mouth or teeth?
□ Thumb, finger or lip sucking habit?
□ continuing □ discontinued
□ Mouth breathing when asleep, awake?
□ Any known missing permanent teeth?
□ Any known extra permanent teeth?
□ Any teeth removed by extraction?
When? _____
□ Is there a tongue thrust problem?
□ Any clenching/grinding of teeth?
□ day □ night □ both
□ Any pain, popping or locking on opening or closing jaw movement?
□ Frequent headaches?
□ Any muscle tenderness or stiffness in jaw or neck area?
□ Any ringing in ear or dizziness?
□ Any previous treatment for TMJ problems?

Please explain all checked responses: _____

Please list your chief concern(s) and what you would like treatment to accomplish:

_____

_____

_____

Has patient ever been □ evaluated or □ treated by any previous orthodontist? If yes, complete below.

Orthodontist: _____ Last seen: _____
Address: _____
Treatment Started: _____

SIGNATURE: _____ DATE: _____