



Orthodontics for Children and Adults

Patient Information					A	B	C
Date _____							
Patient's Name _____							
		Last		First		Middle	
Address _____							
		Street		City		State Zip	
Nickname _____		Birthdate _____		Age _____		Sex _____ Social Security # _____	
If patient is a minor, give parent or guardians' name _____							
Whom may we thank for referring you to our office? _____							

Responsible Party Information									
Name _____									
		Last		First		Middle		Marital Status	
Residence _____									
		Street		City		State		Zip	
Mailing Address _____									
		Street		City		State		Zip	
How long at this address? _____		Home Phone _____		Work Phone _____					
Previous Address (if less than 3 yrs) _____									
		Street		City		State		Zip	
Social Security # _____		Birthdate _____		Relationship to Patient _____					
Employer _____		Occupation _____		No. Years Employed _____					
Spouse's Name _____									
		Last		First		Middle		Relationship to Patient _____	
Employer _____		Occupation _____		No. Years Employed _____					
Social Security # _____		Birthdate _____		Work Phone _____					

Insurance Information	
Insured's Name _____	Insured's Social Security # _____
Insurance Company _____	Group Number _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	
Do you have secondary coverage? (circle one) YES NO If yes: _____	
Insured's Name _____	Insured's Social Security # _____
Insurance Company _____	Group Number _____
Insurance Co. Address _____	Phone _____
Insured's Employer _____	

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone Number \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

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

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



## Orthodontics for Children and Adults

### Adult History

Patient Name \_\_\_\_\_

What is your chief concern for us at this visit? \_\_\_\_\_

\*\*Please circle Y (yes) or N (no) for the following questions, whichever applies. Your answers are for our records only and will be considered confidential. Please use the space after the question for additional explanations.

#### Medical History

- Y N Are you in excellent health?
- Y N Has there been any change in your general health within the last year?
- Y N My last physical exam was \_\_\_\_\_ (month/year)
- Y N Are you now under the care of a physician? If so, what is being treated? \_\_\_\_\_
- Y N Have you had a serious illness/hospitalization in the past 5 years?  
If so, for what? \_\_\_\_\_
- Y N Are you taking any medication (incl. non-prescription)? \_\_\_\_\_

Do you have any of the following conditions?

Allergies or drug reactions to:

- |   |   |
|---|---|
| Y N Latex   | Y N Abnormal bleeding or blood transfusion  |
| Y N Penicillin or other antibiotics   | Y N Low blood pressure  |
| Y N Sulfa drugs   | Y N Cardiovascular disease (heart trouble, attack, angina, high blood pressure, arteriosclerosis, stroke) |
| Y N Aspirin, Ibuprofen, Tylenol   | Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease                 |
| Y N Local anesthetics   | Y N Arthritis or joint problems or artificial joints/limbs  |
| Y N Codeine or other narcotics  | Y N Require pre-medication before dental visits?  |
| Y N Other _____   | Y N Birth Defects   |
| Y N Respiratory problems, emphysema   | Y N Kidney trouble  |
| Y N Asthma or hay fever   | Y N Tuberculosis  |
| Y N Sinus trouble   | Y N Bone fractures or trauma to face or jaw   |
| Y N Persistent swollen neck glands  | Y N Vision, hearing or speech difficulty  |
| Y N Thyroid or endocrine problems   | Y N Persistent Cough  |
| Y N Diabetes  | Y N Frequent colds or sore throats  |
| Y N Hepatitis, jaundice or liver disease  | Y N Frequent headaches  |
| Y N AIDS or HIV infection   | Y N Stomach ulcer or hyperacidity   |
| Y N Sexually transmitted disease  | Y N Tumor (Cancerous or benign)   |
| Y N Substance abuse problem (past or present)   | Y N Radiation therapy or Chemotherapy   |
| Y N Mental health problem or nervous disorder   | Y N Females: Are you pregnant?  |
| Y N Fainting spells or seizures   |   |
| Y N Epilepsy or other neurological disease  |   |
| Y N Fainting spells or seizures   |   |
| Y N Blood disorder such as anemia   |   |
| Y N Do you have any disease, condition or problem not listed above that you think we should know about? |   |

If so, please explain \_\_\_\_\_

## Dental History

Name of patient's dentist \_\_\_\_\_

Date of last dental exam \_\_\_\_\_

- Y N Chipped or injured permanent teeth  
Y N Teeth sensitive to hot or cold  
Y N Jaw fractures, cyst, mouth infections  
Y N Previous root canal therapy  
Y N Bleeding gums or bad taste/mouth odor  
Y N Other periodontal (gum) problems  
Y N Problems with food trapped between teeth  
Y N Frequent canker sores or cold sores  
Y N Mouth breathing habit or snoring troubles  
Y N Abnormal swallowing (tongue thrust)  
Y N Have you had a negative dental experience?

- Y N History of missing or extra teeth  
Y N Have any permanent teeth been removed?  
Y N Have wisdom teeth been removed?  
Y N Teeth that irritate tongue, cheek, lip, etc.  
Y N Previous orthodontic treatment or retainer  
Y N Previous periodontal (gum) treatment  
Y N Numerous fillings  
Y N Damaged restorations or fillings  
Y N Thumb or finger habit as a child  
Y N Loose or shifting teeth  
Y N Is all dental work completed at this time?

## TMJ History

- Y N Have you had a TMJ screening?  
Y N Do you have a history of jaw joint problems?  
Y N Have you been treated for "TMJ"?  
Y N Do you grind your teeth?  
Y N Do you clench your teeth?  
Y N Has your jaw ever locked?  
Y N Does your bite feel uncomfortable or unusual?

- Y N Do you have pain in your jaw joint?  
Y N Do you experience soreness in the muscles of your face or around ears?  
Y N Do you notice clicking or popping in your jaw joint?  
Y N Do you have difficulty chewing or opening your mouth?

## Patient Motivation For Orthodontic Treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (circle the words more, less, forward, etc.)

Teeth - If your teeth could be changed, how would you like them to change?

- |   |   |
|---|---|
| <input type="checkbox"/> Straighten the front teeth — upper / lower | <input type="checkbox"/> Eliminate crowding of teeth — upper / lower    |
| <input type="checkbox"/> Straighten the back teeth — upper / lower  | <input type="checkbox"/> Eliminate spaces between teeth — upper / lower |
| <input type="checkbox"/> Move upper teeth — forward / backward      | <input type="checkbox"/> Make the line of upper teeth more level        |
| <input type="checkbox"/> Move lower teeth — forward / backward      | <input type="checkbox"/> Other _____                                    |

Face - If your facial appearance could be changed, what would you change?

- |  |  |
|--|--|
| <input type="checkbox"/> Move upper lip — forward / backward   | <input type="checkbox"/> Make my nose — longer / shorter |
| <input type="checkbox"/> Move lower lip — forward / backward   | <input type="checkbox"/> Get rid of sag under lower jaw  |
| <input type="checkbox"/> Show — more / less — of my teeth when I smile                               | <input type="checkbox"/> Move chin — forward / backward  |
| <input type="checkbox"/> Show — more / less — of my gums when I smile                                | <input type="checkbox"/> Move chin — left / right        |
| <input type="checkbox"/> Reduce the strain in my — chin / lips — when I close my lips                | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> Make my lips — closer together / farther apart — when my teeth are touching |  |

Symptoms - If you want to reduce pain or discomfort, please be specific about its location; circle the right or left side or both if they apply.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> In front of ears — right / left | <input type="checkbox"/> My temples — right / left   | <input type="checkbox"/> My jaw joints — right / left |
| <input type="checkbox"/> Below ears — right / left       | <input type="checkbox"/> My eyes — right / left      | <input type="checkbox"/> My teeth                     |
| <input type="checkbox"/> Above ears — right / left       | <input type="checkbox"/> My neck — right / left      | <input type="checkbox"/> My sinuses                   |
| <input type="checkbox"/> In my ears — right / left       | <input type="checkbox"/> My shoulders — right / left | <input type="checkbox"/> Other _____                  |

\*\*I certify that I have read and understand the above. I acknowledge that I have completed this form to my best knowledge, and that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any changes later to this history record or medical or dental status, I will inform the practice.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_

Update Signature \_\_\_\_\_

Date \_\_\_\_\_