



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 _____ Relationship to Patient _____					
		Last	First	Middle	
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



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Child/Adolescent 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 Is the patient in excellent health?
- Y N Has there been any change in the patient's general health within the last year?
- Y N Patient's last physical exam was _____ (month/year)
- Y N Is the patient now under the care of a physician? If so, what is being treated? _____
- Y N Has the patient had a serious illness/hospitalization in the past 5 years?
If so, for what? _____
- Y N Is the patient taking any medication (include. non-prescription)? _____

Does the patient have any of the following conditions?

Allergies or drug reactions to:

- | | |
|---|---|
| Y N Latex | Y N Low blood pressure |
| Y N Penicillin or other antibiotics | Y N Cardiovascular disease (heart trouble, heart attack, angina, high blood pressure, arteriosclerosis, stroke) |
| Y N Sulfa drugs | Y N Damaged or artificial heart valves, including heart murmur or rheumatic heart disease |
| Y N Aspirin, Ibuprofen, Tylenol | Y N Does the patient need pre-medication prior to dental visits? |
| Y N Local anesthetics | Y N Arthritis or joint problems or artificial joints/limbs |
| Y N Codeine or other narcotics | Y N Birth Defects |
| Y N Other _____ | Y N Kidney trouble |
| Y N Respiratory problems, emphysema | Y N Tuberculosis |
| Y N Asthma or hay fever | Y N Bone fractures or trauma to face or jaw |
| Y N Sinus trouble | Y N Vision, hearing or speech difficulty |
| Y N Persistent swollen neck glands | Y N Persistent cough |
| Y N Thyroid or endocrine problems | Y N Frequent colds or sore throats |
| Y N Diabetes | Y N Frequent headaches |
| Y N Hepatitis, jaundice or liver disease | Y N Stomach ulcer or hyperacidity |
| Y N AIDS or HIV infection | Y N Tumor (Cancerous or benign) |
| Y N Sexually transmitted disease | Y N Radiation therapy or Chemotherapy |
| Y N Substance abuse problem (past or present) | Y N Tonsils or adenoids removed? What age? _____ |
| Y N Mental health problem or nervous disorder | Y N Is patient's height and weight normal for his/her age? |
| Y N Fainting spells or seizures | |
| Y N Epilepsy or other neurological disease | |
| Y N Blood disorder such as anemia | |
| Y N Abnormal bleeding or blood transfusion | |
| Y N Does the patient 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 History of missing or extra teeth
Y N Teeth sensitive to hot or cold	Y N Have any permanent teeth been removed?
Y N Jaw fractures, cyst, mouth infections	Y N Have wisdom teeth been removed?
Y N Previous root canal therapy	Y N Teeth that irritate tongue, cheek, lip, etc.
Y N Bleeding gums or bad taste/mouth odor	Y N Previous orthodontic treatment or retainer
Y N Other periodontal (gum) problems	Y N Previous periodontal (gum) treatment
Y N Problems with food trapped between teeth	Y N Numerous fillings
Y N Frequent canker sores or cold sores	Y N Damaged restorations or fillings
Y N Mouth breathing habit or snoring troubles	Y N Thumb or finger habit as a child
Y N Abnormal swallowing (tongue thrust)	Y N Loose or shifting teeth
Y N Has there been a negative dental experience?	Y N Is all dental work completed at this time?
Y N Would you consider the patient's diet high in sweets/sugars?	
Patient's deciduous ("baby") teeth came in <input type="checkbox"/> EARLY <input type="checkbox"/> AVERAGE <input type="checkbox"/> LATE	
Patient's deciduous ("baby") teeth were lost <input type="checkbox"/> EARLY <input type="checkbox"/> AVERAGE <input type="checkbox"/> LATE	
Patient's mouth most resembles <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> BOTH <input type="checkbox"/> NEITHER	

Has another family member received orthodontic care? Y N Who? _____

TMJ History

Y N Has the patient had a TMJ screening?	Y N Does the patient have pain in his/her jaw joint?
Y N Does the patient have a history of jaw joint problems?	Y N Does the patient experience soreness in the muscles of his/her face or around ears?
Y N Has the patient been treated for "TMJ"?	Y N Does the patient notice clicking or popping in his/her jaw joint?
Y N Does his/her bite feel uncomfortable or unusual?	Y N Does the patient have difficulty chewing or opening his/her mouth?
Y N Does the patient grind his/her teeth?	
Y N Does the patient clench his/her teeth?	
Y N Has the patient's jaw ever locked?	

Patient Motivation For Orthodontic Treatment

Patients and their general dentists often request changes in 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 profile of 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 teeth when smiling | <input type="checkbox"/> Move chin — forward / backward |
| <input type="checkbox"/> Show — more / less — of gums when smiling | <input type="checkbox"/> Move chin — left / right |
| <input type="checkbox"/> Reduce the strain in — chin / lips — when lips close | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Make lips — closer together / farther apart — when 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"/> Temples — right / left | <input type="checkbox"/> My jaw joints — right / left |
| <input type="checkbox"/> Below ears — right / left | <input type="checkbox"/> Eyes — right / left | <input type="checkbox"/> My teeth |
| <input type="checkbox"/> Above ears — right / left | <input type="checkbox"/> Neck — right / left | <input type="checkbox"/> Sinuses |
| <input type="checkbox"/> In ears — right / left | <input type="checkbox"/> 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 my child's form. If there are any changes later to this history record or medical or dental status, I will inform the practice.

Signature of Parent/Guardian _____	Date _____
Update Signature _____	Date _____
Update Signature _____	Date _____