

# WELCOME!

To help us meet your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

## PATIENT INFORMATION

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M/F \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 If Student, Name of School \_\_\_\_\_  
 If Minor, Name of Parent(s)/Guardian(s) \_\_\_\_\_  
 Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_  
 How Did You Find Out About Us? \_\_\_\_\_

## RESPONSIBLE PARTY INSURANCE INFORMATION

Name of Insured/Person \_\_\_\_\_ Relationship \_\_\_\_\_  
 Responsible for this Account \_\_\_\_\_ to Patient \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Driver's License Number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
 Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## PHYSICIAN / DENTIST INFORMATION

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_  
 Dentist \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam/ Cleaning \_\_\_\_\_  
 Does patient need to return to dentist for any fillings or other procedures? Yes / No  
 If yes, please describe: \_\_\_\_\_

What is the patient's (parent's) primary concern - why are you here?

\_\_\_\_\_  
 \_\_\_\_\_

# PATIENT MEDICAL HISTORY

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	8. Are you allergic to or have you had any reactions to the following:		
2. Have you ever been hospitalized for any surgery or serious illness in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____			Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which medications? _____			Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have or have you had any of the following:			9. Women only:		
<b>Yes</b>	<b>No</b>		Are you pregnant or think you may be?	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<b>Yes</b>	<b>No</b>	<b>Yes</b>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement, Implant	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach Trouble/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Tonsil/Adenoid Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Eye, Ear, Throat Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>

# PATIENT DENTAL HISTORY

	<b>Yes</b>	<b>No</b>		<b>Yes</b>	<b>No</b>
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	7. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel pain from any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have any lumps or sores in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you ever had difficult extractions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you had any thumb or finger sucking habit? Until _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever experienced any of the following problems in your jaw joints:			12. Do you have an abnormal swallow, tongue thrust, or speech problem?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	13. Do you usually breath through your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	14. Have you had any orthodontic treatment? If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			

Realizing that successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments, and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment? \_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

\_\_\_\_\_  
Signature of Parent/Patient

\_\_\_\_\_  
Date

Medical History Update or Changes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_