

Patient's Legal Name: _____ Nickname: _____

Birthdate: ____/____/____ Age: _____ Sex: Male/ Female Marital Status : S/M/W/D School/Grade: _____

Home Address: _____

Email: _____

Home Phone #: (____) _____ Mobile Phone #: _____ Mobile carrier: _____

Hobbies/Interest: _____ Siblings/Ages: _____

Emergency Contact
Name: _____ Relationship: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION "REQUIRED"

Name: _____ Birthdate: ____/____/____ Relationship: _____

Billing Address: _____ How long at this address: _____

Employer: _____ Cell/Work #: _____ Ext: _____ How long: _____

Name: _____ Birthdate: ____/____/____ Relationship: _____

Billing Address: _____

Employer: _____ Cell/Work #: _____ Ext: _____ How long: _____

GENERAL INFORMATION

General Dentist: _____ Last Visit Date: _____

Other Dental Specialists: _____

Whom May We Thank For Referring You? _____

Does anyone else in the family need orthodontics? Yes / No If Yes, who? _____

DENTAL INSURANCE

Primary
Ins. Co. Name: _____ Group #: _____

Ins. Co. Address: _____

Ins Co. Phone: (____) _____ Insured ID #: _____

Insured's Name: _____ Relation: _____ D.O.B: _____

Insured's Employer: _____

MEDICAL HISTORY

Your current health is: Good ___ Fair ___ Poor ___
 Do you have a personal physician? ___Y ___N
 Physician's Name: _____
 Phone #: () _____ Date of last visit: _____
 Are you currently under the care of a physician? ___Y ___N
 Please explain: _____
 Are you taking any prescription/over-the-counter drugs? ___Y ___N
 Please list each one: _____
 Are you pregnant? ___Y ___N

Have you ever had any of the following diseases or medical problems?

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N High/Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints/Valves	<input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma/Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing/Snoring	<input type="checkbox"/> Y <input type="checkbox"/> N Radiation Treatment
<input type="checkbox"/> Y <input type="checkbox"/> N Drug/Alcohol Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic/Scarlet Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N Severe/Frequent Headaches
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Shingles
<input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease/Traits
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Ulcers
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery/Pacemaker	<input type="checkbox"/> Y <input type="checkbox"/> N Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease

Are you allergic to any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin
<input type="checkbox"/> Y <input type="checkbox"/> N Any Metals/Plastics	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N Codeine	<input type="checkbox"/> Y <input type="checkbox"/> N Other
<input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics	Please list any other drugs/materials
<input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin	you are allergic to: _____
<input type="checkbox"/> Y <input type="checkbox"/> N Latex	_____

CONSENT TO THE USE OF RECORDS

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment and retention for purposes of professional consultations, research, education, publication in professional journals, scientific papers, demonstration or marketing purposes. In addition, when i-CAT images are taken, the orthodontist will interpret only those areas consistent with a 2D panorex or ceph. The patient is welcome to have these images further diagnosed by a radiologist for more details at their cost.

Signature

Date

THANK YOU FOR FILLING OUT THIS FORM COMPLETELY

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian of the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

DENTAL HISTORY

What are the main concerns that you would like orthodontics to address?

Have you ever had or been evaluated for orthodontic treatment? ___Y ___N
 Have you ever had a problem associated with previous dental work? ___Y ___N
 Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? ___Y ___N

Your current dental health is: ___ Good ___ Fair ___ Poor ___
 Do your gums ever bleed? ___ Yes ___ No ___
 Have you ever had an injury to: ___ Mouth ___ Teeth ___ Chin ___
 Do you have any missing or extra permanent teeth? Y ___ N ___
 Have you ever taken bisphosphonate? Y ___ N ___

Have you ever experienced any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Pacifier
<input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking
<input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust

Sleep Behavior:

Do you snore? ___Y ___N
 Do you grind your teeth during sleep? ___Y ___N
 Do you seem tired during the day? ___Y ___N

INFORMATION & CONSENT

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date