

▼ about you

male female today's date: _____

name: _____
last first mi mr. mrs. ms. dr.

e-mail address: _____

i prefer to be called: _____

birthday: ____/____/____ single married
 divorced separated

home address: _____
app/condo #

city state zip

hm #: (____) _____ mobile #: (____) _____

wk #: (____) _____

employer or school and grade: _____

employer's address: _____
city state zip

how long there?: _____ occupation: _____

where and when are the best times to reach you?

what is the best way to contact you?
(please circle) home phone mobile e-mail

whom may we thank for referring you?: _____

names and ages of children or siblings: _____

previous/present dentist: _____
(please circle)

▼ release

I authorize the doctor to perform diagnostic procedures and treatment as may be necessary for proper dentofacial care. I authorize release of any information concerning my (or my child's) health care for the purpose of evaluation and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care for advice and treatment to interdisciplinary team members. I consent to the release of credit reports and information regarding my credit history to the doctor(s). I authorize the taking of photographs, radiographs and other diagnostic records before, during and after treatment, and to the use of the same by the doctor or interdisciplinary team members in scientific presentations or scientific literature.

Patient/Guardian: _____ date: _____

Patient/Guardian: _____ updated: _____

▼ responsible parties

▶ person financially responsible for account

self father mother other*

*If 'other', please fill out 'other' section below

▶ father | stepfather dob: ____/____/____

name: _____
first mi last

employer: _____ ss#: _____

wk # (____) _____ hm # (____) _____

e-mail: _____

▶ mother | stepmother dob: ____/____/____

name: _____
first mi last

employer: _____ ss#: _____

wk # (____) _____ hm # (____) _____

e-mail: _____

▶ other dob: ____/____/____

name: _____
first mi last

employer: _____ ss#: _____

wk # (____) _____ hm # (____) _____

e-mail: _____ relationship: _____

▶ person to contact in case of emergency

name: _____ relationship: _____

best # to reach them: (____) _____

▼ medical history

do you have a personal physician? yes no

physician's name: _____

physician's phone number: (____) _____

date of last visit: _____

are you currently under the care of a physician? yes no

please explain: _____

do you smoke or use tobacco in any other form? yes no

are you taking any prescription/over-the-counter drugs?

yes no | please list each one: _____

have you ever taken bisphosphonates (such as fosamax, reclast, boniva) for cancer therapy or osteoporosis? yes no

have you ever had any of the following?

(please circle)

y n abnormal bleeding/ hemophilia	y n HIV-positive test or exposure
y n AIDS	y n hospitalized for any reason
y n alcohol/drug abuse	y n kidney problems
y n arthritis	y n liver disease
y n artificial bones/joints/valves	y n lupus
y n asthma	y n mitral valve prolapse
y n cancer/chemotherapy	y n pacemaker
y n congestional heart defect	y n psychiatric/emotional problems
y n diabetes	y n radiation treatment
y n difficulty breathing	y n rheumatic/scarlet fever
y n epilepsy	y n seizures
y n fainting spells	y n shingles
y n frequent headaches	y n sickle cell disease/traits
y n heart attack/surgery	y n stroke
y n heart murmur	y n thyroid problems
y n hepatitis	y n tuberculosis
y n herpes/fever blisters	y n ulcers
y n high blood pressure	y n sleep apnea

please list any serious medical condition(s) that you have ever had, or elaborate on any of the above. _____

have you ever been told that you need antibiotics prior to dental treatment? yes no

.....

for women: are you pregnant? yes no

▼ dental history

what are your main concerns that you would like orthodontics to address? _____

is there a history of thumb/finger sucking? yes no

is there a history of tongue-thrusting? yes no

Is there a family history of underbites or overbites? yes no

do you have any speech problems? yes no

do you generally breath through your mouth? yes no

(if yes please circle) **while awake?** **while asleep?**

have you had or been evaluated for orthodontic treatment? yes no

do you now have or ever experience pain/discomfort in your jaw joint (TMJ/TMD)? yes no

when was your last cleaning? _____

have you ever had an injury to your: **mouth teeth chin**
(please circle)

describe: _____

do you generally have difficulty breathing through your nose? yes no

are you happy with the way your smile looks? yes no

if not what would you change? _____

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 that it is my responsibility to inform this office of any changes in my medical status.

signature

date

▼ office use only

i verbally reviewed the medical/dental information with the patient named herein.

initials

date

doctor's comments: _____
