ORTHODONTIC PATIENT INFORMATION

Welcome to our office.

The following information is requested to help us better understand your orthodontic needs during your initial examination in our office. We must have accurate background and health information to enable the orthodontist to thoroughly diagnose any condition. This information is confidential. Please circle the appropriate response where indicated.
Thank you.

PATIENT'S NAME____ AGE_____ BIRTH DATE___________ SEX_____

HOME ADDRESS ____ HOME PHONE________________
STREET CITY ZIP

PATIENT'S OCCUPATION OR SCHOOL LEVEL ______________________________WORK PHONE_______________

SCHOOL PATIENT ATTENDS (if applicable) ____

PERSON RESPONSIBLE FOR ACCOUNT ___________________________________HOME PHONE______________

RELATIONSHIP________________ SOCIAL SECURITY #__________________ EMPLOYED BY_________________

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? YES NO

IF YES, BY WHICH COMPANY? ____

NAME OF PERSON TO BE CONTACTED IF PATIENT CANNOT BE REACHED

NAME____ RELATIONSHIP___________

ADDRESS____ PHONE_____________

FAMILY DENTIST_____________________________ FAMILY PHYSICIAN_________________________

REFERRED BY _____________________

FAMILY STATUS

SIBLINGS: ______NONE _______ # OF BROTHERS _______# OF SISTERS

FATHER'S NAME ____ LIVING YES NO

MOTHER'S NAME ____ LIVING YES NO

OTHER FAMILY MEMBERS WITH SIMILAR ORHTODONTIC CONDITION?

FATHER _____BROTHER ______ MOTHER _____ SISTER ____ OTHER _____

SPECIFY____

PATIENT LIVING WITH: MOTHER _____ FATHER _____ SELF ______ OTHER ______

MEDICAL AND DENTAL HISTORY:

HEALTH: GOOD FAIR POOR CURRENTLY UNDER TREATMENT YES NO

SPECIFY: ____

CURRENTLY TAKING DRUGS OR MEDICATION? YES NO

SPECIFY: ____

HAS PATIENT BEEN UNDER THE CARE OF A PHYSICIAN DURING THE PAST TWO YEARS OTHER THAN FOR ROUTINE EXAMINATION? YES NO

BIRTH DEFECTS YES NO

SPECIFY: ____

HAS PATIENT REACHED PUBERTY (Adult Physical Development)? YES NO

The following conditions are of interest to the orthodontist:

Has the patient ever had?

Aids	Endocrine Problems	Hepatitis
Asthma	Emotional Problems	Herpes
Anemia	Fainting	Hypertension
Bleeding Disorder	Gum Disorders	Malignancies (Cancer)
Bone Disorder	Heart Disease	Mouth Lesions
Diabetes	Hearing Disorder	Rheumatic Fever
Epilepsy	Head or Face Injury	Tuberculosis
		Unintentional Weight Loss

Comments:____

____

Does the Patient:

1. Have allergies to   Seasonal grasses _________________   Food _______________________
   Drugs __________________________   Other ______________________
2. Snore when sleeping?   Yes   No
3. Breathe through mouth?   Seldom   Sometimes   Usually
   Comments:____
4. Have frequent colds?   Yes   No
5. Have frequent sore throat or tonsillitis?   Yes   No
6. Have difficulty chewing or swallowing?   Yes   No

Has the patient received medical treatment from an allergist or ear, nose and throat specialist?   Yes   No

I yes, When________________________, By Whom____

Tonsils removed? Yes   No   Adenoids removed?   Yes   No

Does the patient have pain or clicking in the jaw joint?   Yes   No

Has the patient had any trauma to the mouth or jaw joint?   Yes   No

Has the patient received or been requested to receive speech correction?   Yes   No

The following habits are of interest to the orthodontist. List information as it pertains to the patient.

Thumb sucking until age ________   Teeth grinding   Yes   No

Finger sucking until age ________   Tongue thrusting   Yes   No

Lip-biting or sucking   Yes   No   Other habits   Yes   No

Has the patient had any unusual dental experiences?   Yes   No

Specify: ____

Has the patient had previous orthodontic consultation or treatment?   Yes   No

Date: _________________________ Dr. ____

If there any other medical, dental or surgical problems not covered above please describe ___________________________________

____

ANY CHANGES IN THE PATIENT'S HEALTH WHILE UNDER OUR CARE SHOULD BE BROUGHT TO OUR ATTENTION.

PATIENT'S DENTAL HEALTH AND AWARENESS

Dental check-ups: Twice a year   Once a year   Only if urgent   Never

Date of last dental check-up ________________________ Were the patient's teeth cleaned?   Yes   No

Is the patient aware of any orthodontic problem?   Yes   No

Patient's interest in orthodontics: Wants treatment   Willing if necessary   Unwilling but agrees   Uncooperative

Orthodontic consultation prompted by: Patient   Dentist   Mother   Father   Spouse

Sibling   Physician   Hygienist   Friend   Other ______________________________________

What is the reason for seeking an orthodontic consultation? ____

What is the primary problem? ____

Has any member of your family had orthodontic treatment?   Yes   No

What is expected from orthodontic treatment? ____

Additional Comments ____

Signature of person completing this form:____

Relationship to patient: ____________________________________ Today's date _______________________