

**Patient Information**

A B C

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ M / F  
Last First Middle Preferred First Name Sex

Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Referred By \_\_\_\_\_ Patient's Physician \_\_\_\_\_

Other family members in treatment \_\_\_\_\_

**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 ( ) \_\_\_\_\_

**Dental Insurance Information**

Policy Holders Name \_\_\_\_\_ Birth date \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Employer \_\_\_\_\_ Ins. Co. Phone # ( ) \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes:

Insured's Name \_\_\_\_\_ Birth date \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured's Employer \_\_\_\_\_ Ins. Co. Phone # ( ) \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

## MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor Under Treatment:  Yes  No

Specify: \_\_\_\_\_

**PRESENT DRUGS OR MEDICATION:**  Yes  No

Specify: \_\_\_\_\_

Has patient been under care of a physician during the past two years other than for routine examination?  Yes  No

Birth Defects  Yes  No

Specify: \_\_\_\_\_

The following conditions are of interest to the orthodontist.

Has the Patient ever had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma         | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes           | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia         | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy           | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Disorder     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No Endocrine Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Head or Face Injury  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Emotional Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS           | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Infections     | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis (any type) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease      | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes (cold sores)  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer             | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease     |

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

Has patient received medical treatment from allergist or ear, nose and throat specialist?

Yes  No if Yes: When: \_\_\_\_\_ By Whom: \_\_\_\_\_

Tonsils removed \_\_\_\_\_ Adenoids removed \_\_\_\_\_

Have any teeth been injured due to accidents or blows to the mouth?  Yes  No

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

Thumb sucking until age \_\_\_\_\_ Grinding of teeth \_\_\_\_\_  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. \_\_\_\_\_

Are there any other medical, dental or surgical problems not covered above?  Yes  No

Have you ever been told by a physician that you must be pre-medicated for any surgical procedures?  Yes  No

Do you have pain in the face, neck or shoulders?  Yes  No

Do you have frequent headaches?  Yes  No

Do you have recurring tooth pain or sensitivity?  Yes  No

Do you have ringing, fullness or pain in your ears?  Yes  No

Do you have difficulty opening your mouth or does your jaw get "stuck" or "locked"?  Yes  No

Do your joints make noises upon opening or closure?  Yes  No

Do you have difficulty or pain with chewing, talking or yawning?  Yes  No

Do you grind or clench your teeth?  Yes  No

Do you have arthritis?  Yes  No

Have you had any previous treatment for your jaw joint (TMJ problem)? If so, when and by whom? \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

### -FOR COMPLETION BY THE DOCTOR-

Comments on patient interview concerning medical history:

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