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Practice Limited to Orthodontics and Dentofacial Orthopedics

PATIENT INFORMATION FORM

Date of Exam_____
Date of Birth_____

Patient's name_____Age_____Sex_____
Last *First* *Initial*

Address: Street:_____ City:_____ State:_____ Zip Code:_____

Phone_____Email Address_____ Referred by _____

Patient's Dentist _____ Patient's Physician:_____

Names of other members of your family treated by our office_____

Person responsible for account: _____ Date of Birth_____

Marital Status: single ☐ married ☐ divorced ☐ remarried ☐ widowed ☐

Social Security Number:_____Address (if different from above) _____

Do you have an insurance plan which covers orthodontic treatment? Yes☐ No☐ Name of Company_____

Occupation _____ Date of Birth_____ Bus. telephone _____

Employed by_____

Spouse's name _____ Bus. telephone _____

Employed by _____ Occupation_____

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	Yes	No		Yes	No		Yes	No
Diabetes.	☐☐	☐☐	Tuberculosis.	☐☐	☐☐	Endocrine or Thyroid	☐☐	☐☐
Pneumonia.	☐☐	☐☐	Anemia.	☐☐	☐☐	Prolonged Bleeding.	☐☐	☐☐
Heart trouble	☐☐	☐☐	Epilepsy	☐☐	☐☐	Liver involvement.	☐☐	☐☐
Rheumatic Fever	☐☐	☐☐	Asthma.	☐☐	☐☐	Fainting and Dizziness.	☐☐	☐☐
Bone Disorders	☐☐	☐☐	Kidney involvement. . . .	☐☐	☐☐	Nervous disorders.	☐☐	☐☐

Yes No ?

Are you in good health?_____ ☐ ☐ ☐
Do you have any history of major illness? _____ ☐ ☐ ☐
List any drugs or medications now being taken. Give reasons._____
Do you have arthritis? _____ ☐ ☐ ☐
List any allergies or drug sensitivity._____
Do you wear contact lenses?_____ ☐ ☐ ☐
Have wisdom teeth been removed? What age?_____ ☐ ☐ ☐
Have you seen a physician in the last 2 years?_____ ☐ ☐ ☐
If yes, why?_____

DENTAL HISTORY

Has there been any injuries to the face, mouth or teeth?_____ □ □ □ □ □ □

Do you have any problems with your speech?_____ □ □ □ □ □ □

Do you breathe predominately through your mouth?_____ □□ □□ □□

Do you have frequent headaches?_____ □□ □□ □□

Have you had any clicking or discomfort in jaw joints near ears?_____ □□ □□ □□

Have you been informed of any missing or extra permanent teeth? _____ □□ □□ □□

Have you had any previous orthodontic examinations?_____ □□ □□ □□

Do you clench or grind your teeth?_____ □□ □□ □□

Have you had any periodontal treatment?_____□□ □□ □□

Are you apprehensive about orthodontic treatment?_____□□ □□ □□

Do you feel that you need orthodontic treatment?_____ □□ □□

□□ When did you last visit your dentist?_____Were any x-rays taken?_____□□ □□ □□

List sports and interests_____

Reason for orthodontic examinations_____

Signature _____