Patient Biographical Information

* First Name:

Middle Initial:

* Last Name:

Nickname:

* Birthdate:

* Gender:

* Address:

* Postal Code:

* Main Phone:

2nd/Cell Phone:

Email:

Alternate e-mail

If patient is a minor, give parent's or guardian's name:

If patient is a minor, who does the patient live with?

Please list the names of any friends or family currently in the practice:

List any sports, hobbies, or musical instruments played:

Whom may we thank for referring you to our practice?

Financial Party Information

☐ **Check if the patient is also the person who will be financially responsible for treatment.**

* First Name:

* Last Name:

Marital Status:

Relationship to Patient:

* Birthdate:

* Address:

* Postal code:

How long at this address?

Previous Address (less than 3 years):

Email:

* Main Phone:

2nd/Cell Phone:

Work Phone #:

ID number:

Employer:

Occupation:

Length of Employment:

Spouse or Other Parent's First Name:

Middle Initial:

Last Name:

Relationship to Patient:

ID number:

Birthdate:

Employer:

Occupation:

Length of Employment:

Work Phone #:

Dental Insurance Information

Policy Holder's Name:

Relationship to Patient:

Insurance Company:

Subscriber ID #

Insurance Plan:

Insurance Co. Phone No.:

Emergency Information

Name of nearest relative not living with you:

Complete Address:

Phone:

Relationship to Patient:

Dental

Dentist Name:

Check-up Frequency:

Last Dental Visit:

MM/YY

Has the patient had an orthodontic consult or treatment?

○ No ○ Yes

If so, when?

*Does the patient need to premedicate prior to dental visit?

○ No ○ Yes

What is the patient's main orthodontic concern?

Please select YES if the patient has had any of the conditions listed below either now or in the past.

* Speech problems/therapy?

○ No ○ Yes

* Clench or Grind Teeth?

○ No ○ Yes

* Oral habits (thumb/finger sucking, lip/nail biting)?

○ No ○ Yes

* Injury to face, jaw, teeth or mouth?

○ No ○ Yes

* Discomfort from teeth or gums?

○ No ○ Yes

* Pain, tenderness or noise in either jaw?

○ No ○ Yes

* Frequent headaches?

○ No ○ Yes

* Neck / Shoulder Pain?

○ No ○ Yes

* Frequent sore throats?

○ No ○ Yes

* Chipped or injured permanent teeth?

○ No ○ Yes

* Teeth sensitive to hot or cold?

○ No ○ Yes

* Previous root canal therapy?

○ No ○ Yes

* Bad taste/mouth odor?
○ No ○ Yes

* Previous periodontal (gum) treatment?
○ No ○ Yes

* Abnormal swallowing (tongue thrust)?
○ No ○ Yes

* Teeth that irritate tongue, cheek, lip, etc?
○ No ○ Yes

* Numerous fillings?
○ No ○ Yes

* Brush teeth daily?
○ No ○ Yes

* Floss teeth daily?
○ No ○ Yes

* Fluoride treatments?
○ No ○ Yes

* Mouth breathing?
○ No ○ Yes

* Snores during sleep?
○ No ○ Yes

* Any missing or extra permanent teeth?
○ No ○ Yes

* Apprehensive about dental care?
○ No ○ Yes

* Frequently Chew Gum?
○ No ○ Yes

* Thumb or finger habit as a child?
○ No ○ Yes

* Jaw fractures, cysts, mouth infections?
○ No ○ Yes

* Bleeding gums?
○ No ○ Yes

* Other periodontal (gum) problems?
No Yes

* Frequent canker sores or cold sores?
No Yes

* Have wisdom teeth been removed?
No Yes

* Problems with food trapped between teeth?
No Yes

* Is all dental work completed?
No Yes

If any of the above dental questions were answered 'Yes', please explain:

* Have you had a TMJ screening?
No Yes

* Do you have a history of jaw joint problems?
No Yes

* Have you been treated for TMJ?
No Yes

* Do you notice clicking or popping in your jaw joint?
No Yes

* Do you clench your teeth?
No Yes

* Has your jaw ever locked?
No Yes

* Do you have difficulty chewing or opening your mouth?
No Yes

* Does your bite feel uncomfortable or unusual?
No Yes

* Do you experience soreness in the muscles of your face or around your ears?
No Yes

If any of the above TMJ questions were answered 'Yes' please explain:

Medical History

Physician Name:

Physician Telephone number:

Date of Last Physical:

Patient Health conditions:

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* Has there been any change in the patient's general health within the last year?

○ No ○ Yes

* Is the patient now under the care of a physician (other than routine)? If so, what is being treated?

○ No ○ Yes

* Has the patient had a serious illness/hospitalization in the past 5 years? If so, what for?

○ No ○ Yes

List any medications currently being taken by the patient (include non-prescription):

Allergies or drug reaction to:

* Latex

○ No ○ Yes

* Penicillin or other antibiotics

○ No ○ Yes

* Sulfa drugs

○ No ○ Yes

* Aspirin, Ibuprofen, Tylenol

○ No ○ Yes

* Local anesthetics

○ No ○ Yes

* Codeine or other narcotics

○ No ○ Yes

* Latex / Metal Allergy

○ No ○ Yes

* Other:

○ No ○ Yes

List any drug allergies or sensitivities (not listed above) that the patient may have:

Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.

* Heart Murmur
  ○ No ○ Yes

* Damaged or artificial heart valves
  ○ No ○ Yes

* Congenital Heart Defect
  ○ No ○ Yes

* Heart Disease
  ○ No ○ Yes

* Rheumatic Fever
  ○ No ○ Yes

* Angina
  ○ No ○ Yes

* Liver Disease / Jaundice / Hepatitis
  ○ No ○ Yes

* Kidney Disease
  ○ No ○ Yes

* Heart Attack / Stroke
  ○ No ○ Yes

* Hemophilia
  ○ No ○ Yes

* Hypertension / High Blood Pressure
  ○ No ○ Yes

* Prolonged Bleeding / Transfusion
  ○ No ○ Yes

* Anemia / Blood Disorder
  ○ No ○ Yes

* HIV / AIDS
  ○ No ○ Yes

* Tonsils / Adenoids Removed
  ○ No ○ Yes

* Handicaps / Disabilities

○ No ○ Yes

* Arthritis / Joint problems
○ No ○ Yes

* Large Tonsils
○ No ○ Yes

* Sinus Trouble
○ No ○ Yes

* Bed Wetting
○ No ○ Yes

* Substance abuse problems (past or present)
○ No ○ Yes

* Bone fractures / Trauma to face / Jaw
○ No ○ Yes

* Prosthetic Joints
○ No ○ Yes

* Chronic Fatigue
○ No ○ Yes

* Diabetes
○ No ○ Yes

* Growth Problems
○ No ○ Yes

* Tuberculosis or Lung Disease
○ No ○ Yes

* Pneumonia
○ No ○ Yes

* Cancer
○ No ○ Yes

* Family History of Cancer
○ No ○ Yes

* Received Radiation Treatment
○ No ○ Yes

* Arteriosclerosis
○ No ○ Yes

* Thyroid / Endocrine Problems
No Yes

* Stomach Ulcer or Hyperacidity
No Yes

* Hormone Therapy
No Yes

* Nervous Disorders
No Yes

* Bone Disorders/Bone Loss
No Yes

* Seizures / Epilepsy / Neurological Disease
No Yes

* Treated for Emotional Problems
No Yes

* Asthma
No Yes

* Respiratory Problems / Emphysema
No Yes

* Persistent swollen neck glands
No Yes

* Sexually Transmitted Disease
No Yes

* Low Blood Pressure
No Yes

* Persistent Cough
No Yes

* FEMALES: Are you pregnant?
No Yes

* Take Bisphosphonates (Fosamax, Boniva)

No Yes

If any of the above medical questions were answered 'Yes' , please explain:

Patient Motivation for Orthodontic Treatment

Patients often request changes in their bites or faces and relief from pain or discomfort. Please help us to understand your concerns by checking the following information; please be specific (check the words - upper, lower, more, etc.)

Teeth - If your teeth could be changed, how would you like them to change?

- [ ] Straighten Front Teeth
  - ○ Upper ○ Lower ○ Both
- [ ] Straighten Back Teeth
  - ○ Upper ○ Lower ○ Both
- [ ] Move Upper Teeth
  - ○ Forward ○ Backward
- [ ] Move Lower Teeth
  - ○ Forward ○ Backward
- [ ] Eliminate Spaces Between Teeth
  - ○ Upper ○ Lower ○ Both
- [ ] Eliminate Crowding of Teeth
  - ○ Upper ○ Lower ○ Both
- [ ] Make Line of Upper Teeth More Level
- [ ] Other:

Face - If your facial appearance could be changed, what would you change?

- [ ] Move Upper Lip
  - ○ Forward ○ Backward
- [ ] Move Lower Lip
  - ○ Forward ○ Backward
- [ ] Show my teeth when I smile
  - ○ More ○ Less
- [ ] Show my gums when I smile
  - ○ More ○ Less
- [ ] Make my nose:
  - ○ Longer ○ Shorter
- [ ] Move chin:
  - ○ Forward ○ Backward
- [ ] Move chin:
  - ○ Left ○ Right
- [ ] Reduce the strain when I close my lips in my:
  - ○ Chin ○ Lips ○ Both
- [ ] When my teeth touch make my lips:
  - ○ Closer Together ○ Farther Apart

Patients Under 18

If patient is under the age of 18, please answer the following questions:

Height:

Weight:

School:

Grade:

Has patient begun puberty:

○ No ○ Yes

If patient is a girl, has menstruation begun:

○ No ○ Yes

If patient is a boy, has their voice changed or have facial hair:

○ No ○ Yes

Has the patient grown in the past year or has their shoe size changed recently:

○ No ○ Yes

Has either biological parent ever had orthodontic treatment:

Don't Know

☐ I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

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

Submit Clear