PATIENT INFORMATION

Patient's Name____

Prefers to be called____

Home Address____

City ______________________________Zip Code______________

Home# (________) ____

Birth Date______________ Age_______ Sex ☐ Male ☐ Female

School ____Grade_______

Patient's interests, hobbies, sports_____________________________

____

If patient is under 18, list name(s) and age(s) of sibling(s) _________

____

Patient's Dentist____

Address____

Phone# (________)____

Who referred you?____

RESPONSIBLE PARTY

Name________________________________Marital Status________

Address____

City ______________________________Zip Code______________

Home# (________) ____

Cell# (________) ____

E-Mail ____

SS#/INS ID# ____

Birth Date ____

Relationship to Patient ____

Employer____

Occupation____

Work# (________) ____

Orthodontic Insurance ____

Spouse's Name_______________________ Marital Status________

Address____

City ______________________________Zip Code______________

Home# (________) ____

Cell # (________) ____

E-Mail ____

SS#/INS ID#_____________________ Birth date_______________

Relationship to Patient ____

Spouse's Employer ____

Occupation ____

Work# (________) ____

Orthodontic Insurance ____

MEDICAL HISTORY

Has the patient been under the care of a physician within the past 2 years?

Explain the condition and duration:______________________________

____

Does the patient have a history of any of the following:

Y	**N**	Mental Disorders	**Y**	**N**	Fainting or Dizziness
Y	**N**	Venereal Disease	**Y**	**N**	Arthritis
Y	**N**	Hepatitis	**Y**	**N**	Anemia
Y	**N**	AIDS or HIV Positive	**Y**	**N**	Have you ever taken "Phen-Phen" or "Redux"
Y	**N**	Epilepsy	**Y**	**N**	Heart Trouble
Y	**N**	Diabetes	**Y**	**N**	Prolonged Bleeding
Y	**N**	Rheumatic Fever	**Y**	**N**	High or Low Blood Pressure
Y	**N**	Asthma			

List any other serious illnesses or operations not mentioned above:

____

List any drugs or medication presently being taken. Give reason:

____

List any allergies or drug sensitivities:___________________________

____

IF PATIENT IS A MINOR

Y **N** Is child adopted?
Y **N** Are any siblings adopted?
Y **N** Any learning disabilities?

DENTAL HISTORY

Y **N** Is there any pain or clicking in the jaw joints?

Y **N** Does the jaw ever lock after opening?

Y **N** Do you clench or grind your teeth?

Y **N** Abnormal swallowing habits (tongue thrust)?

Y **N** Have there been any injuries to the mouth, teeth, or jaw?

Y **N** Has the patient ever seen an Orthodontist, had orthodontic treatment, worn a "retainer", or "bite plate"?
If so when?________________________________
By whom?________________________________

When were the last dental x-rays? ____________________________

When was the last teeth cleaning? ____________________________

What is your reason for seeking an orthodontic evaluation?

____

____

List anything else you think the doctor should know.

____

I have truthfully answered all the above questions and agree to inform this office of any changes in medical or dental history on the above stated patient. In addition, I authorize the doctor to perform a complete orthodontic evaluation.

Signature: ___________________________ Date_________________

Relationship to patient____

IF YOU HAVE DENTAL INSURANCE, PLEASE PRESENT YOUR CARD TO THE FRONT OFFICE STAFF.

CH-EX 08/14