

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Nickname or Preferred Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex M[\_] F[\_]  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Has any family member received treatment at our office? Yes[\_] No[\_] if yes, who? \_\_\_\_\_  
 Dentist \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Time at this address \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Email \_\_\_\_\_  
 Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
 Current Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to patient \_\_\_\_\_  
 Current Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Work Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_ May we call you/spouse at work? Yes[\_] No[\_] Email \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Insurance Company (Primary) _____	Insurance Company (Secondary) _____
Address _____	Address _____
Phone Number (____) ____ - ____	Phone Number (____) ____ - ____
Group Number _____	Group Number _____
Policy Holder Name _____	Policy Holder Name _____
Policy Holder Soc. Sec. No. ____ - ____ - ____	Policy Holder Soc. Sec. No. ____ - ____ - ____
Policy Holder Birth Date ____ / ____ / ____	Policy Holder Birth Date ____ / ____ / ____
Policy Holder Employer _____	Policy Holder Employer _____

**INITIAL EXAM INFORMATION**

What is your chief concern in seeking orthodontic care? \_\_\_\_\_  
 What is your dentist's main concern regarding the patient's bite? \_\_\_\_\_  
 In an effort to avoid records duplication: has another orthodontist been consulted previously? Yes[\_] No[\_]

**Our policy is that the adult who requests treatment is responsible for all fees for services rendered.  
 When appropriate, credit information will be obtained.**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SIGNATURE ON FILE**

- By signing below:
- I authorize the use of this form and its information for all my insurance submissions.
  - I authorize this office and its employees to act as my agent in helping me obtain insurance reimbursement.
  - I authorize insurance payment directly to this office.
  - I authorize the use of a copy of this form which can be used in place of the original.
  - I understand where appropriate a credit report may be obtained.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICAL HISTORY**

Name of physician \_\_\_\_\_ Physician's Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**please check yes or no for each condition (if yes, please explain)**

<i>Allergies</i>		Yes [ ] No [ ] AIDS or HIV positive	Yes [ ] No [ ] Oral ulcers
Yes [ ] No [ ] Acrylic		Yes [ ] No [ ] Cancer	Yes [ ] No [ ] Respiratory problems
Yes [ ] No [ ] Aspirin		Yes [ ] No [ ] Chemo	Yes [ ] No [ ] Rheumatic fever
Yes [ ] No [ ] Ibuprofen		Yes [ ] No [ ] Radiation	
Yes [ ] No [ ] Latex			<i>Sensory conditions</i>
Yes [ ] No [ ] Metals			Yes [ ] No [ ] Hearing
Yes [ ] No [ ] Nickel		<i>Cardiovascular conditions</i>	Yes [ ] No [ ] Tasting
Yes [ ] No [ ] Vinyl	Yes [ ] No [ ] Angina	Yes [ ] No [ ] Heart attack	Yes [ ] No [ ] Vision
Yes [ ] No [ ] Other _____	Yes [ ] No [ ] Heart defect	Yes [ ] No [ ] Heart murmur	Yes [ ] No [ ] Other _____
	Yes [ ] No [ ] Stroke	Yes [ ] No [ ] Other _____	Yes [ ] No [ ] Speech condition (if yes, explain) _____
Yes [ ] No [ ] Arthritis (Rheumatism)			
Yes [ ] No [ ] Asthma			
Yes [ ] No [ ] Attention Deficit Disorder			
	<i>Neurological disorders</i>		Yes [ ] No [ ] Tonsils/adenoids
<i>Blood disorders</i>	Yes [ ] No [ ] Epilepsy		Yes [ ] No [ ] Tuberculosis
Yes [ ] No [ ] Anemia	Yes [ ] No [ ] Fainting		Yes [ ] No [ ] Does your child have any other medical conditions that we should know about?
Yes [ ] No [ ] Bruise easily	Yes [ ] No [ ] Seizures		
Yes [ ] No [ ] Excessive bleeding	Yes [ ] No [ ] Other _____		
Yes [ ] No [ ] Other _____			
	<i>Blood pressure conditions</i>		If yes, please explain _____ _____ _____ _____
Yes [ ] No [ ] high	Yes [ ] No [ ] Eating disorder		
Yes [ ] No [ ] low	Yes [ ] No [ ] Headaches/migraines		
	Yes [ ] No [ ] Hepatitis		
	Yes [ ] No [ ] Immune system disorder		
	Yes [ ] No [ ] Kidney disorders		

**MEDICATION HISTORY**

Yes [ ] No [ ] Do you take any prescription medication, over the counter medication, nutritional supplements, or herbal medication?

**Please list all medications...**

Medication	Taken for
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**DENTAL HISTORY**

- Yes  No  Do you have missing teeth?
- Yes  No  Do you have extra teeth?
- Yes  No  Do you have slowly erupting teeth?
- Yes  No  Do you have unerupted teeth?
- Yes  No  Do you have thin gum tissue?
- Yes  No  Do you brush and floss regularly?

- Yes  No  Are you in good dental health?
- Yes  No  Are your x-rays and fluoride treatments up to date?
- Yes  No  Have you seen the dentist in the past six months?
- Yes  No  Have you experienced any unusual dental problems?
- Yes  No  Is there anything else about your child's dental history that we should know about?

If yes to any above, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Now or in the past have you had...**

- Yes  No  ...any history of injured teeth?
- Yes  No  ...injury to the head, neck, or jaws?
- Yes  No  ...tooth sensitivity to hot or cold?
- Yes  No  ...history of dental problems?
- Yes  No  ...periodontal or "gum tissue" problems?
- Yes  No  ...bleeding gums when brushing?
- Yes  No  ...food impaction between teeth?
- Yes  No  ...frequent canker sores or cold sores?

*Jaw joint history*

- Yes  No  ...history of jaw joint pain?
- Yes  No  ...history of jaw joint clicking or locking?
- Yes  No  ...history of facial muscle pain
- Yes  No  ...difficulty chewing, opening, or closing?
- Yes  No  ...history of treatment for TMD or TMJ?

*Functional/habit history*

- Yes  No  ...history of thumb or finger habit?
- Yes  No  ...history of tongue thrusting?
- Yes  No  ...history of abnormal swallowing?
- Yes  No  ...difficulty eating?
- Yes  No  ...history of mouthbreathing?
- Yes  No  ...history of snoring?
- Yes  No  ...history of tooth grinding?
- Yes  No  ...history of jaw clenching?
- Yes  No  ...history of speech difficulty?
- Yes  No  ...any history of speech therapy?

If yes to any above, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Successful orthodontic treatment and beautiful smiles are achieved with a combination of appropriate diagnosis, excellent communication, and personalized attention. In an effort to specifically address your orthodontic concerns, please indicate what you would like orthodontics to accomplish for you:

- Enhance aesthetics and appearance
- Improve function, comfort, and stability
- Enhance overall dental health
- Create facial balance
- Increase self confidence
- Avoid further problems

I have read and understand the previous questions and I certify that the information I have provided is complete and accurate. In addition I acknowledge that I am solely responsible for any errors or omissions that may have been made in the completion of this four page form. As the responsible party I will immediately inform this office in the event of any change in medical and/or dental health status and will acknowledge change in status by signing and dating below.

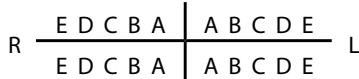
**Signature** \_\_\_\_\_ **On behalf of** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(responsible party) (patient)

**MEDICAL / DENTAL HISTORY UPDATE**

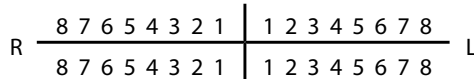
Date	Medical/dental status change?	Signature	Change in status
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		

**FOR OFFICE USE ONLY**

*Deciduous teeth present*



*Permanent teeth present*



*Crossbites*



*Molar and Canine classification*

	Right side		Left side	
	Molar	Canine	Molar	Canine
Class I				
End to End II				
Class II				
Class III				

*Skeletal*

	R	L	
Class I	[ ]	[ ]	
Class II	[ ]	[ ]	
Class III	[ ]	[ ]	
Upper midline	[ ]	[ ]	_____ mm
Lower midline	[ ]	[ ]	_____ mm

*Mild Moderate Severe*

Upper Crowding	[ ]	[ ]	[ ]
Lower Crowding	[ ]	[ ]	[ ]
Overbite	_____	%	
Frenum	Inv. [ ]	Not Inv. [ ]	
Midline Diastema	_____	mm	
Overjet	_____	mm	

Date	Recommendation