

PATIENT INFORMATION

Last Name _____ First Name _____ Preferred Name _____
 Birth Date ____/____/____ Age ____ Sex M[_] F[_] School _____ Grade ____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____
 Activities/Hobbies _____ Ages of Siblings (____) (____) (____) (____)
 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 _____

If a parent (responsible party) is not living with the patient, please complete the following

Last Name _____ First Name _____ Birth Date ____/____/____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) ____ - ____ Work Phone (____) ____ - ____ Cell Phone (____) ____ - ____

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 parent/guardian 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 patient's physician _____ Physician's Phone (_____) _____ - _____

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

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

MEDICATION HISTORY

Yes No Is your child taking any prescription medication, over the counter medication, nutritional supplements, or herbal medication?

Please list all medications...

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

DENTAL HISTORY

- | | |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have missing teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient in good dental health? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have extra teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> Are the patient's x-rays and fluoride treatments up to date? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have slowly erupting teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> Has the patient seen the dentist in the past six months? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have unerupted teeth? | Yes <input type="checkbox"/> No <input type="checkbox"/> Is the patient cooperative/ helpful during dental treatment? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have thin gum tissue? | Yes <input type="checkbox"/> No <input type="checkbox"/> Has the patient experienced any unusual dental problems? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient brush and floss regularly? | Yes <input type="checkbox"/> No <input type="checkbox"/> 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 has your child 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 your family:

- | | | |
|--|---|--|
| <input type="checkbox"/> Enhance aesthetics and appearance | <input type="checkbox"/> Improve function, comfort, and stability | <input type="checkbox"/> Enhance overall dental health |
| <input type="checkbox"/> Create facial balance | <input type="checkbox"/> Increase self confidence | <input type="checkbox"/> 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.

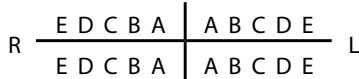
Signature _____ **On behalf of** _____ **Date** ___/___/___
(responsible party) (patient)

MEDICAL / DENTAL HISTORY UPDATE

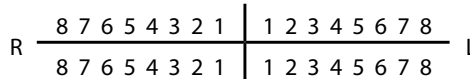
Date	Medical/dental status change?	Signature	Change in status
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []		
	Yes [] No []	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

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

Date	Recommendation