

**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.

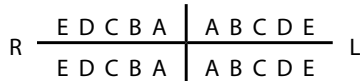
**Signature** \_\_\_\_\_ **On behalf of** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(responsible party) (patient)

**MEDICAL / DENTAL HISTORY UPDATE**

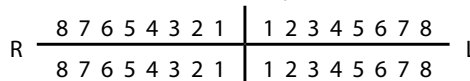
Date	Medical/dental status change?	Signature	Change in status
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes [ ] No [ ]		
	Yes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