PATIENT INFORMATION

Date:

Patient's Name: Age: Sex: Birthdate:

Prefers to be addressed by: Email:

Address: City: Zip: Home Phone:

How did you hear about our office: Cell Phone:

Patient's Dentist: Date of Last Visit:

PERSON RESPONSIBLE FOR ACCOUNT

❑ Same as Above - Or - Name: Relationship to patient:

❑ Same as Above - Or - Address: Social Security #:

Best Contact Phone #:

MINOR PATIENTS (UNDER 18 YEARS)

Mother's Name: Occupation: Cell Phone:

Mother's Employer: Work Phone:

Father's Name: Occupation: Cell Phone:

Father's Employer: Work Phone:

Parents' Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Siblings
Name: DOB:

Siblings
Name: DOB:

Guardian (If Applicable) Home phone:

Guardian's Employer: Occupation: Cell Phone:

ADULT PATIENTS (OVER 18 YEARS)

Employed by: Occupation: Work Phone: SS #:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: Occupation: Employed by: Work Phone:

DENTAL HISTORY

1. Have there been any injuries to the face, mouth or teeth? ❑ YES ❑ NO

2. Have you had or do you presently have any of the following habits? ❑ Thumb or Finger Sucking ❑ Lip Biting ❑ Snoring ❑ No ❑ Grinding of Teeth at Night ❑ Mouth Breathing

3. Have you been informed of any missing or extra permanent teeth? ❑ YES ❑ NO

4. Are you aware of sores, lumps or irritated areas in the mouth? ❑ YES ❑ NO

5. Has an orthodontist been consulted previously? ❑ YES ❑ NO
Name: Date:

6. Has the patient ever been treated for: ❑ NO ❑ Bad Bite ❑ TMJ ❑ Periodontal Disease If so, by whom?:

7. Do you have any speech problems? ❑ YES ❑ NO

8. Are you frightened or anxious about Orthodontic Treatment? ❑ YES ❑ NO

9. Are you concerned about the appearance of your teeth? ❑ YES ❑ NO

10. Is there anything you would like to change about your smile. If so, what? ❑ YES ❑ NO

11. What aspect of dental treatment are you most concerned with? ❑ Quality ❑ Cost ❑ Discomfort ❑ Time

12. Reason for consultation (Chief Concern):

13. Has there ever been any orthodontic treatment for any other member of the family? ❑ YES ❑ NO
Were you satisfied with the results: ❑ YES ❑ NO
Father (Dr. _____) Mother (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)

MEDICAL HISTORY

COMMENTS:

1. Is the patient's general health good at this time?	❑ YES ❑ NO
2. What is the name of family physician at this time?	Date of last physical:
3. Is the patient under the care of a physician at this time?: Explain:	❑ YES ❑ NO
4. Is the patient taking any medication? Name:	❑ YES ❑ NO
5. Is the patient allergic to any medication? (Penicillin, Sulfa, etc.) Name:	❑ YES ❑ NO
6. Does the patient have a latex allergy? Nickel allergy?	❑ YES ❑ NO ❑ YES ❑ NO
7. Has the patient had tonsils and / or adenoids removed? Age:	❑ YES ❑ NO
8. Has the patient ever had a serious illness or been hospitalized? Explain:	❑ YES ❑ NO
9. Does the patient have any special problems not listed? Explain:	❑ YES ❑ NO
10. Has the patient ever been advised by their physician to take an antibiotic prior to any dental treaments? If Yes, antibiotic name and method:	❑ YES ❑ NO
11. What is the patient's approximate height?	weight?

DOES THE PATIENT NOW, OR HAVE THEY EVER HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	TUBERCULOSIS	❑	❑	RESPIRATORY LUNG DISEASE	❑	❑	ADD
❑	❑	ENDOCARDITIS	❑	❑	HIGH BLOOD PRESSURE	❑	❑	KIDNEY TROUBLE
❑	❑	HEART CONDITION	❑	❑	LOW BLOOD PRESSURE	❑	❑	LIVER DISEASE
❑	❑	HEART PACEMAKER	❑	❑	HEPATITIS (TYPE?_____)	❑	❑	PSYCHIATRIC TREATMENT
❑	❑	HEART ANGINA	❑	❑	VENEREAL DISEASE	❑	❑	DRUG ADDICTION
❑	❑	HEART ATTACK (CORONARY)	❑	❑	HERPES (ORAL-COLD SORES)	❑	❑	HEADACHES
❑	❑	MITRAL VALVE PROLAPSE	❑	❑	BLOOD DISORDERS/BLEEDING PROBLEMS	❑	❑	EARACHES
❑	❑	CONGENITAL HEART DISEASE	❑	❑	INFLAMMATORY RHEUMATISM	❑	❑	JAW CLICKING
❑	❑	ARTIFICIAL HEART VALVE	❑	❑	ARTHRITIS	❑	❑	ALLERGIES
❑	❑	HEART SURGERY; date _____	❑	❑	ULCERS	❑	❑	ALLERGIES TO METAL
❑	❑	HEART MURMUR	❑	❑	STROKE	❑	❑	JAW PAIN
❑	❑	RHEUMATIC FEVER	❑	❑	ANEMIA	❑	❑	TONSILLITIS
❑	❑	PROSTHETIC (ARTIFICIAL) JOINT	❑	❑	ASTHMA	❑	❑	EMOTIONAL PROBLEMS
❑	❑	X-RAY/RADIATION (CANCER) THERAPY	❑	❑	EPILEPSY	❑	❑	OTHER: _____
❑	❑	AIDS OR H.I.V. POSITIVE	❑	❑	GLAUCOMA			
❑	❑	DIABETES	❑	❑	FAINTING SPELLS			

MEMO:

CHILD/ADOLESCENT SUPPLEMENTAL

12. School Attending:	Grade:
13. Sports/Hobbies:	
14. Has the patient shown signs of increased growth recently?	❑ YES ❑ NO
15. Has the patient reach puberty? Girls-started menstruating? Boys-voice changed?	❑ YES ❑ NO ❑ YES ❑ NO ❑ YES ❑ NO
16. Father's present height: _____ Older brother's present height: _____	Mother's present height: _____ Older sister's present height: _____

I, the undersigned, have completed the health questionnaire and certify that the preceding information is true and correct. THIS OFFICE WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INFORMATION NOT DISCLOSED. I grant authority to the Doctor and Staff to perform all procedures and treatments in the patient's best interest. I understand that, where appropriate, Credit Bureau reports may be obtained.

Signature of Patient, Parent or Guardian	Today's Date