ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of the form and bring to the front desk. DATE_____

Please Print Patient Information **(Responsible Party Information to follow)**

Name _____Age _____ Birthday _____/_____/_____ Sex M / F

Home Address _____ City _____ ZIP Code _____

Cell Phone _____ Home Phone _____ Email _____

School Name / City _____/_____

Referred By: This is VERY important for us to track where our patients are coming from.

- ☐ Parent or Direct family member already treated here. Do Not select dentist if you were already treated here.
  - Family Member's name who was treated _____
- ☐ Dentist. **Must be referred to us by name from your dentist or staff, or provided referral**
  - Name of staff who referred our name_____
- ☐ Friend. **Name is important, so they receive our referral gift!**
  - Name of friend who referred our name _____
- ☐ Company Website True Orthodontics, PC. Website.

☐ Search Engine ○ Yahoo ○ Firefox ○ Google ○ Bing	☐ Social Media ○ Facebook ○ Instagram ○ Twitter ○ YouTube	☐ Sign on buildings ☐ Yellow Pages ○ Paper books ○ Yellow Pages online

Person (s) responsible for financial matters:

	Primary	Secondary
Name (s)	_____	_____
Street	_____	_____
City/zip	_____/_____	_____/_____
Home/Cell	_____	_____
Employer	_____	_____
Occupation	_____	_____

Is patient covered by insurance for orthodontic treatment? If yes, which company _____

Who has the coverage (circle) Father Mother Other

SSN of subscriber(s) _____ _____

Birthdate of subscriber(s) _____ _____

Family Dentist _____ City _____

Family Physician _____ City _____

Family History

Father's Name _____ Living? No / Yes Occupation _____

Mother's Name _____ Living? No / Yes Occupation _____

Marital status of Parents: (circle) Married / Divorced / Single

Patient living with: _____ Both Parents _____ Mother _____ Father ____ Other _____

Sibling(s) (Name and age): _____

Medical History

Has the patient ever had: (circle)

AIDS	Bleeding	Epilepsy/Seizures	Herpes	Nickel Allergy	Other: _____
Allergy	Cold Sores	Head or Face Injury	HIV +	Oral Ulcer	_____
Anemia	Diabetes	Hearing Problems	Kidney Disease	Rheumatic Fever	Previous Surgeries:
Arthritis	Endocrine Probs.	Heart Condition	Latex Allergy	Thyroid Problems	_____
Asthma	Emotional Probs.	Hepatitis	Lung Disease		_____

Has the patient ever been under the care of a physician during the past two years, other than for routine examination?
No / Yes. Condition _____

Does this patient require premedication for dental procedures? No / Yes

Present drugs or medications _____

Birth Defects _____

Has the Patient reached puberty (menstruation, hair)? No / Yes (This information needed for growth purposes)

Respiratory History

Does the patient:

1. Have allergies to: ____ Seasonal Grasses ____ Food _____ Drugs Please list known allergies: _____
2. Breathe through the mouth? Seldom Sometimes Usually
3. Snore when sleeping? No Yes
4. Have frequent colds? No Yes
5. Have frequent "stuffy nose?" No Yes
6. Have frequent sore throat or tonsillitis? No Yes
7. Have chewing or swallowing difficulty? No Yes

Has the patient received medical treatment from allergist or ear, nose and throat specialist? No / Yes

If Yes: When _____ By Whom: _____

___ Nasal Surgery ___ Tonsils removed ___ Adenoids removed

Dental and Temporomandibular Joint History

Has the patient had any unusual dental experiences? No Yes

Specify _____

Date of last dental checkup ____/___/_____ Were the patient's teeth cleaned? No Yes

The following habits are of interest. List information as it pertains to this patient:

1. Thumb/finger/lip sucking until _____ (age)? No Yes
2. Grinding or clenching of teeth? No Yes
3. Tongue thrusting or another functional problem? No Yes

Has the patient ever had a previous orthodontic consultation or treatment? No Yes

Date: _____ Dr. _____

Why did patient seek this consultation? _____

Additional comments you wish to make _____

Signature: _____ Relationship to patient: _____ Date: ____/____/_____