Building a community of great smiles

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Welcome to Our Office

Tell us about yourself

Name ❑Mr. ❑Mrs. ❑Ms. ❑Dr. ❑Rev. ______________________________ (first / middle / last)
❑Female ❑Male ❑Married ❑Single
Nickname or preferred greeting ______________ Age ______ Birthdate ______________
Home address ______________ City ______________ State ______ Zip ______
Home phone ( ) ______________ Cell phone/Pager ( ) ______________ Bus. phone ( ) ______________
Email ______________
Occupation ______________ Employer ______________
Spouse's name ______________ Occupation ______________ Bus. phone ( ) ______________
Dentist's name ______________ Phone ( ) ______________ City ______________ Date of last visit ______________
Have you ever been seen by an orthodontist? ❑yes ❑no If yes, please explain: ______________
____
Physician's name ______________ Phone ( ) ______________ City ______________ Date of last physical ______________
Other family member(s) seen at our office ______________
How did you hear about our office? ______________
Why did you select our office? ______________

Insurance Information

Any dental coverage? ❑yes ❑no Any orthodontic coverage? ❑yes ❑no
Primary policyholder's name ______________ Relationship ______________ Birthdate ______________
SS# ______-______-______ Insurance company ______________ Group/Policy # ______________
Insured's employer ______________
Secondary policyholder's name ______________ Relationship ______________ Birthdate ______________
SS# ______-______-______ Insurance company ______________ Group/Policy # ______________
Insured's employer ______________

For the following questions mark yes, no, or don't know/understand (dk/u). Your answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Patient Profile

❑ yes ❑ no ❑ dk/u Do you brush your teeth conscientiously?

❑ yes ❑ no ❑ dk/u Are you sensitive or self-conscious about your teeth?

❑ yes ❑ no ❑ dk/u Do you have any learning disabilities or need extra help with instructions? Please explain:
____
____

Medical History

Now or in the past, have you had:

❑ yes ❑ no ❑ dk/u Asthma
❑ yes ❑ no ❑ dk/u Hayfever
❑ yes ❑ no ❑ dk/u Frequent colds, sore throats, sinus trouble
❑ yes ❑ no ❑ dk/u Pneumonia, emphysema, bronchitis
❑ yes ❑ no ❑ dk/u Tuberculosis
❑ yes ❑ no ❑ dk/u Chew or smoke tobacco
❑ yes ❑ no ❑ dk/u Kidney problems
❑ yes ❑ no ❑ dk/u Endocrine or thyroid problems
❑ yes ❑ no ❑ dk/u Diabetes
❑ yes ❑ no ❑ dk/u Polio, mononucleosis
❑ yes ❑ no ❑ dk/u Problems with the immune system
❑ yes ❑ no ❑ dk/u Aids, HIV positive
❑ yes ❑ no ❑ dk/u High or low blood pressure
❑ yes ❑ no ❑ dk/u Shortness of breath or swelling of ankles
❑ yes ❑ no ❑ dk/u Anemia, excessive bruising or bleeding
❑ yes ❑ no ❑ dk/u Bone fractures, any major accidents
❑ yes ❑ no ❑ dk/u Hepatitis, jaundice or liver problem
❑ yes ❑ no ❑ dk/u History of eating disorder (anorexia, bulimia)
❑ yes ❑ no ❑ dk/u Stomach ulcer or hyperacidity
❑ yes ❑ no ❑ dk/u Rheumatoid or arthritic condition
❑ yes ❑ no ❑ dk/u Birth defects or hereditary problems
❑ yes ❑ no ❑ dk/u Sexually transmitted disease
❑ yes ❑ no ❑ dk/u Mental health disturbances or depression
❑ yes ❑ no ❑ dk/u Loss of weight recently, poor appetite
❑ yes ❑ no ❑ dk/u Vision, hearing or speech difficulties
❑ yes ❑ no ❑ dk/u Skin disorder
❑ yes ❑ no ❑ dk/u Cancer, tumor, radiation or chemotherapy
❑ yes ❑ no ❑ dk/u ADD / ADHD
❑ yes ❑ no ❑ dk/u Frequent headaches
❑ yes ❑ no ❑ dk/u Eat a well-balanced diet
❑ yes ❑ no ❑ dk/u Heart problem (chest pain, heart attack, arteriosclerosis, stroke, congenital heart defect, mitral valve prolapse, damaged or artificial heart valves, heart murmur or rheumatic heart disease)

Please continue on reverse side

❑ yes ❑ no ❑ dk/u   Do you require antibiotic premedication before dental cleanings?
❑ yes ❑ no ❑ dk/u   Do you currently have, or ever had a substance abuse problem?
❑ yes ❑ no ❑ dk/u   Allergies? If so, to what? ____

❑ yes ❑ no ❑ dk/u   Operations or hospitalizations? Describe: ____

❑ yes ❑ no ❑ dk/u   Being treated by another healthcare professional? For: ____

❑ yes ❑ no ❑ dk/u   Other physical problems or medical conditions? Describe: ____

Women only:
❑ yes ❑ no ❑ dk/u   Are you currently pregnant?

Any prescription medicine:

Medication: ______________________   Taken for: ______________________
Medication: ______________________   Taken for: ______________________
Medication: ______________________   Taken for: ______________________

Dental History

Now or in the past, have you had:

❑ yes ❑ no ❑ dk/u   Any missing or extra permanent teeth
❑ yes ❑ no ❑ dk/u   Permanent teeth removed
❑ yes ❑ no ❑ dk/u   Bleeding gums when brushing teeth
❑ yes ❑ no ❑ dk/u   Periodontal gum problems or treatment
❑ yes ❑ no ❑ dk/u   Cysts or mouth infections
❑ yes ❑ no ❑ dk/u   Frequent canker sores or cold sores
❑ yes ❑ no ❑ dk/u   History of speech problems or therapy
❑ yes ❑ no ❑ dk/u   Teeth sensitive to hot or cold
❑ yes ❑ no ❑ dk/u   Food impaction between teeth
❑ yes ❑ no ❑ dk/u   Chipped or injured teeth
Please explain: ______________________

❑ yes ❑ no ❑ dk/u   Injury to the face, chin or jaw
Please explain: ______________________

❑ yes ❑ no ❑ dk/u   Any relative with similar tooth or jaw conditions
❑ yes ❑ no ❑ dk/u   Concern about under or over developed jaw
❑ yes ❑ no ❑ dk/u   Tooth grinding or clenching
❑ yes ❑ no ❑ dk/u   Any pain in TMJ (jaw joint) around the ears
❑ yes ❑ no ❑ dk/u   Any pain or soreness in the muscles of the face
❑ yes ❑ no ❑ dk/u   Difficulty w/ chewing or jaw opening/locking
❑ yes ❑ no ❑ dk/u   Mouth breathing, snoring or difficulty breathing
❑ yes ❑ no ❑ dk/u   Abnormal swallowing habit (tongue thrusting)
❑ yes ❑ no ❑ dk/u   Aware of loose, broken or missing fillings
❑ yes ❑ no ❑ dk/u   Any needed dental work (fillings, crowns, etc.) that is not completed? Please explain: ______

❑ yes ❑ no ❑ dk/u   Any previous trouble with dental treatment?
Please explain: ______________________

What is your chief concern or reason for your visit today? ____

I have read and understood the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ______________________________ Date Signed: ______________
(Patient)

Signed: ______________________________ Date Signed: ______________
(Orthodontic staff member)