

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ School: _____ Grade: _____

Who else have we treated in your family? _____

How did you hear about our office or who referred you? _____

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Spouse or Other Parent: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Primary Dental Insurance

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone # _____

Member ID# _____ Group # _____ Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone # _____

Member ID# _____ Group # _____ Insured's Employer: _____

Consent to Exam

I understand that a pre-treatment exam and records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, facial and intra-oral digital photographs and a digital scan. I hereby consent to this complete orthodontic examination and to the taking of any necessary pretreatment records.

Name: _____ Signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Confidential Patient Health History

Medical History

Primary Physician: _____ Phone: _____ Approximate date of last dental cleaning: _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Please confirm whether or not the patient has been treated for any of the following:

- | | | |
|--|--|---|
| ☐ Yes ☐ No Heart Conditions (murmur, etc.) | ☐ Yes ☐ No HIV Positive | ☐ Yes ☐ No Hepatitis |
| ☐ Yes ☐ No Excessive Bleeding | ☐ Yes ☐ No Tuberculosis | ☐ Yes ☐ No Frequent Headaches |
| ☐ Yes ☐ No Diabetes | ☐ Yes ☐ No Asthma | ☐ Yes ☐ No Kidney Infections |
| ☐ Yes ☐ No Rheumatic Fever | ☐ Yes ☐ No Epilepsy | ☐ Yes ☐ No Cerebral Palsy |
| ☐ Yes ☐ No Liver Problems | ☐ Yes ☐ No Birth Defects | ☐ Yes ☐ No Eyesight Problems |
| ☐ Yes ☐ No Cancer | ☐ Yes ☐ No Infections | ☐ Yes ☐ No Speech Impairments |
| ☐ Yes ☐ No Nervous Disorders | ☐ Yes ☐ No ADHD | ☐ Yes ☐ No Autism |
| ☐ Yes ☐ No Other _____ | | |

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: _____

Is the patient allergic to any plastics or metals? ☐ Yes ☐ No If yes, list: _____

Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? ☐ Yes ☐ No

Does the patient need to be medicated prior to dental appointments? ☐ Yes ☐ No

Have tonsils or adenoids been removed? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Dental and Orthodontic History

General Dentist (name of office): _____ Approximate date of last dental cleaning _____

Is there any dental work to be completed? (Fillings, crowns, etc.). ☐ Yes ☐ No _____

Have there been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No _____

Has the patient ever sucked their fingers or thumb? ☐ Yes ☐ No Until what age? _____

Does the patient have any speech problems? ☐ Yes ☐ No _____

Is the patient a mouth breather while asleep or awake? ☐ Yes ☐ No _____

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No _____

Is there pain/popping/clicking in the jaw joint? ☐ Yes ☐ No When did this begin? _____

Does the patient clench or grind? ☐ Yes ☐ No _____

Does the patient regularly have headaches? ☐ Yes ☐ No _____

Does the patient gag easily? ☐ Yes ☐ No _____

Has the patient ever had orthodontic treatment? ☐ Yes ☐ No _____

Has the patient ever had a previous orthodontist exam? ☐ Yes ☐ No _____

Have any family members had orthodontic treatment? ☐ Yes ☐ No _____

What is the chief concern that brought you to our office? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Health History Update

Patient Initial: _____ Date: _____

Doctor: _____ Date: _____