307 ORTHODONTICS

PATIENT INFORMATION (Please Complete This Section + "Responsible Party Information" Below)

Patient's Last Name:_____ First Name: _____ Middle Initial:_____

Birth Date:_____ Age:_____ Sex: Male ❑ Female ❑ Patient's Nickname:_____

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

Attends School At (ages 18 and under):_____ City:_____ Grade:_____

Name(s) of other family seen here:_____

Whom may we thank for referring you?_____ Phone #: _____

Patient's Dentist:_____ City:_____ Date of Last Exam:_____

(Skip next 2 questions if over 18 years of age)

Who is accompanying the patient today?_____ Relation:_____

Who has legal custody of this child?_____ Phone #: _____ home / cell / work *(circle one)*

RESPONSIBLE PARTY INFORMATION (This May Be Yourself if You are the Patient, Please Complete)

Parent's Marital Status: Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single ❑

#1)

MUST COMPLETE

Responsible Party Name:_____ Relation to Patient:_____ Email:_____

Birth Date: _____ Driver's License #:_____ State:_____ SS#:_____

Home Phone #:_____ Work #:_____ Cell #:_____ Daytime #: home / cell / work *(circle one)*

Employer:_____ Dental Insurance: Yes ❑ No ❑ (If no, skip the following section)

Insurance Company:_____ Insurance Co. Address:_____

Insurance Phone #:_____ Group #:_____ Subscriber ID or SSN #:_____

#2)

Parent's Marital Status: Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single ❑

Responsible Party Name:_____ Relation to Patient:_____ Email:_____

Birth Date: _____ Driver's License #:_____ State:_____ SS#:_____

Home Phone #:_____ Work #:_____ Cell #:_____ Daytime #: home / cell / work *(circle one)*

Employer:_____ Dental Insurance: Yes ❑ No ❑ (If no, skip the following section)

Insurance Company:_____ Insurance Co. Address:_____

Insurance Phone #:_____ Group #:_____ Subscriber ID or SSN #:_____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you:_____ Relation to Patient:_____

Address: _____ Phone: _____ home / cell / work *(circle one)*

☒ ***Signature:***_____ ***Date:***_____ ***Relation to Patient:***_____

HEALTH QUESTIONNAIRE

PATIENT PROFILE

How would the patient like to improve his/her smile?_____

Why do you think orthodontic treatment is needed?_____

Are there any other family members with a similar condition/_____

Has the patient had any prior orthodontic treatment or appliances?_____

Is there any information that would help us better treat the patient?_____

MEDICAL HISTORY

Name of Physician and/or Clinic:_____ Phone #: _____

Physician's Address:_____ Date of Last Exam:_____

ALLERGY TO: LATEX? Yes ❑ No ❑ PLASTICS? Yes ❑ No ❑ METALS? Yes ❑ No ❑

ANTIBIOTICS? Yes ❑ No ❑ If yes, please list:_____

OTHER ALLERGIES? Yes ❑ No ❑ If yes, please list:_____

_____

MEDICATIONS: (list all medications, vitamins, supplements/herbal medications being taken and why)_____

_____

ENDOCRINE OR THYROID PROBLEMS? Yes ❑ No ❑ If yes, please list:_____

EATING DISORDER? Yes ❑ No ❑ If yes, please list:_____

CANCER, TUMOR, RADIATION OR CHEMOTHERAPY? Yes ❑ No ❑ If yes, please list:_____

OTHER MEDICAL CONDITIONS? Yes ❑ No ❑ If yes, please list:_____

DENTAL HISTORY

Have there been any accidents or trauma to the teeth or face? Yes ❑ No ❑ If yes, please list:_____

Have any teeth been removed? Yes ❑ No ❑ If yes, please list:_____

Any other dental conditions or problems we should be aware of? Yes ❑ No ❑ If yes, please list:_____

Has the dentist pointed to some orthodontic problem? Yes ❑ No ❑ If yes, please list:_____

Any pain or clicking in opening mouth? Yes ❑ No ❑ If yes, please list:_____

THUMB SUCKER? Yes ❑ No ❑ TONGUE THRUSTER? Yes ❑ No ❑ MOUTH BREATHER? Yes ❑ No ❑

☒ ***Signature:***_____ ***Date:***_____ ***Relation to Patient:***_____

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