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SPECIALIZING IN
ORTHODONTICS

BRACES AND INVISALIGN
FOR CHILDREN, TEENS & ADULTS

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security #: _____

Address: _____

Home Ph: _____ Cell Ph: _____ Email:

_____

Employer: _____ Work Ph: _____

Responsible Party #1 (Self, Parent, Guardian…):_____

Relation to Patient: _____

Address (if different):_____

Cell Ph: _____ Home Ph: _____ Work Ph: _____

Responsible Party #2 (Spouse, Parent, Guardian…):_____

Relation to Patient: _____

Address (if different):_____

Cell Ph: _____ Home Ph: _____ Work Ph: _____

Who referred you to our office? _____

Please list any relatives seen in this practice: _____

Dental Insurance

Policy Holder's Name: _____ SSN: _____

Date of Birth: _____ Employer: _____

Insurance Co: _____ Group #: _____ ID #: _____

Ins. Co. Address: _____ Ins. Co. Ph:_____

Medical History

Physician: _____Date of Last Visit: _____

Address: _____Phone:_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____

Yes No Do you have any allergies? _____

Yes No Do you have a history of a major illness? _____

Yes No Have you had any operations? _____

Yes No Have you ever been involved in a serious accident? _____

Yes No Have you ever smoked or chewed tobacco?_____

Yes No Have seen a physician in the last 12 months? Why? _____

Yes No Are you pregnant? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness/Fainting	Herpes	Low Blood Pressure
Difficulty Hearing	Thyroid Problems	Sensory/Developmental Concerns	
Arthritis	Epilepsy/Seizures	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Mental Health Disorders	Tumor or Cancer

Are there any other medical conditions we should be aware of? _____

Dental History

General Dentist: _____ Date of last visit:

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain?

Yes No Have you ever experienced any unfavorable reaction to dentistry?_____

Yes No Have your wisdom teeth been removed?_____

Yes No Have you ever lost or chipped any teeth? _____

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

Yes No Is any part of your mouth sensitive to temperature? Where? _____

Yes No Is any part of your mouth sensitive to pressure? Where?_____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any type of thumb or tongue habit?_____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No What is your attitude toward receiving orthodontic treatment? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches?_____

Yes No Have you ever experienced chronic ringing in your ears?_____

Yes No Are you aware that some appointments will be during work hours? _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous. It is my responsibility to inform the dental office of any changes in my (or my child's) medical status. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to myself or child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for my payment of all services rendered on myself or behalf of my child.

Signature of Patient or Parent:_____ Date: _____