



Date: _____

Patient's Full Name: _____ Prefers to be called: _____

Patient's Address: _____

Home Phone: _____ Cell Phone: _____

Patient's Email Address: _____

Patient's Birthday: _____ Age: _____ SSN: _____

Male Female Married Single Divorced

Patient's Dentist: _____ Date of Last Visit _____

Whom may we thank for referring you? _____

Names and ages of children: _____

Other family members seen by us: _____

Your Employer: _____

Occupation: _____ Work phone: _____

Spouse's Name: _____ Spouse's birthday: _____

Spouse's Cell phone: _____ Spouse's Work phone: _____

Spouse's Employer: _____ Occupation: _____

Emergency Contact and Phone (if different than spouse): _____

Primary Dental Insurance Information

Insured's Name: _____ Insured's SSN: _____

Insured's Employer: _____ Insured's Birthday: _____

Employer Address: _____

Insurance Company Name: _____

Insurance Company Address: _____

Group Number (Plan, local or policy No): _____

Health History

Medical History

(please check if patient has, or has had...)

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Drug Addiction/Use | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Asthma/Breathing Problems | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Tonsils Removed |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestinal Problems | |

Please explain all checked responses:

List any allergies:

List any medications:

Dental History

(please check if patient has, or has had...)

- | | |
|---|---|
| <input type="checkbox"/> Any injuries to face, mouth or teeth? | <input type="checkbox"/> Any clenching/grinding of teeth? |
| <input type="checkbox"/> Thumb, finger or lip sucking habit? | <input type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Both |
| <input type="checkbox"/> continuing <input type="checkbox"/> discontinued | <input type="checkbox"/> Frequent Headaches? |
| <input type="checkbox"/> Mouth breathing when asleep, awake? | <input type="checkbox"/> Any pain, popping or locking on opening or closing jaw movement? |
| <input type="checkbox"/> Any known missing permanent teeth? | <input type="checkbox"/> Any muscle tenderness or stiffness in jaw or neck area? |
| <input type="checkbox"/> Any known extra permanent teeth? | <input type="checkbox"/> Any ringing in ear or dizziness? |
| <input type="checkbox"/> Any teeth removed by extraction? | <input type="checkbox"/> Any previous treatment of TMJ problems? |
| When? _____ | |
| <input type="checkbox"/> Is there a tongue thrust problem? | |

Please explain all checked responses:

Please list your chief concern(s) and what you would like treatment to accomplish:

Have you ever been evaluated or treated by any previous orthodontist? If yes, complete below.

Orthodontist: _____ Date last seen: _____

Address: _____

Type of treatment: _____

SIGNATURE: _____ **Date:** _____