

Patient Information

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

S.S.N.: _____

Birth Date: _____ Age: _____ Sex: Male Female

Minor Married Widowed Single

Separated Divorced Partnered for _____ years

Patient's Address: _____ E-mail Address : _____

City: _____ State: _____ Zip Code: _____

Attends School At: _____ Grade: _____

Patient/Guardian Employer _____

Occupation _____

Employer Address _____

Employer Phone (____) _____

Spouse's Name _____

Birthdate _____

S.S.N.: _____ Spouse's Employer _____

Whom may we thank for referring you? _____

Name of Patient's Dentist: _____ Telephone No: _____

Dentist's Address: _____

City: _____ State: _____ Zip Code: _____

Date Last Seen _____ Reason _____

Name of Patient's Physicians: _____

Telephone No(s) _____

Physician's Address: _____

City: _____ State: _____ Zip Code: _____

Date Last Seen: _____ Reason _____

Dental Insurance

Who is Financially Responsible for this Account? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is the patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

ASSIGNMENT AND RELEASE

I certify and I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company (ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

Dental History

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of Last dental visit _____

Date of Last Dental X-rays _____

Birth Father's Height: ___ft. ___in.

Birth Mother's Height: ___ft. ___in

Patient's Birth Weight: ___lbs. ___oz.

Patient's Present Weight: ___lbs

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection the teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chewing on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Loose teeth or broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth pain, brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sores or growths in your mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____	
		How often do you brush? _____	

Health History

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No

- | | | | |
|---------------------------------|--|--------------------------|--|
| Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date: _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

Medications:

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone(____) _____

Allergies:

None Known

Aspirin Local Anesthetic Barbiturates (sleeping pills) Codeine

Iodine Latex Penicillin Sulfa

Vinyl Acrylic Foods(specify) _____

Animals Other _____

Yes No Are you currently taking or have you ever taken any intravenous bisphosphonates for serious bone disorders/cancers, such as Zometa (zoledronic acid), Aredia (pamidronate), and Didronel (etidronate)?

Yes No Are you currently taking or have you ever taken any oral bisphosphonates for osteoporosis, osteopenia or other uses, such as Fosamax (alendronate), Actonel (risendronate), Boniva (ibandronate), Skelid (tiludronate), and Didronel (etidronate)? Please name the medication and length of time on the medication.

Medication _____ Length of time taken _____

Medication _____ Length of time taken _____

Yes No Is the patient taking medication, nutrients supplements, herbal medications or non-prescription medicine? Please name them:

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

- Yes No Does the patient currently has or ever had a substance abuse problem?
 Yes No Does the patient chew or smoke tobacco?
 Yes No Operations? Describe: _____

 Yes No Hospitalized? Describe: _____

 Yes No Other physical problems or symptoms? Describe: _____

 Yes No Being treated by another health professional?
For: _____
Date of most recent physical exam? _____

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

Girls Only:

- Yes No Has the patient started her monthly periods?
If so, approximately when? _____
 Yes No Is the patient pregnant?

Family Medical History:

Do the patient's parents or siblings have any of the following health problems?

Bleeding disorders _____

Arthritis _____

Metabolic disturbances _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Any other family medical conditions that we should know about?

Dental History:

- Yes No Started teething very early or late?
 Yes No Primary (baby) teeth removed that were not loose?
 Yes No Permanent or "extra" (supernumerary) teeth removed?
 Yes No Supernumerary (extra) or congenitally missing teeth?
 Yes No Chipped or otherwise injured primary (baby) or permanent teeth?
 Yes No Teeth sensitive to hot or cold; teeth throb or ache?
 Yes No Jaw fractures, cysts or mouth infections?
 Yes No "Dead teeth" or root canals treated?
 Yes No Bleeding gums, bad taste or mouth odor?
 Yes No Periodontal "gum problems"?
 Yes No Food impaction between teeth?
 Yes No Thumb, finger, or sucking habit? Until what age _____?
 Yes No Abnormal swallowing habit? (tongue thrusting)?
 Yes No History of speech problems?
 Yes No Mouth breathing habit, snoring or difficulty in breathing?
 Yes No Tooth grinding or jaw clenching?
 Yes No Any pain in jaw or ringing in the ears?
 Yes No Any pain or soreness in the muscles of the face or around the ears?
 Yes No Difficulty encountered in chewing or jaw opening?
 Yes No Aware of loose, broken or missing restorations (fillings)?
 Yes No Any teeth irritating cheek, lip, tongue or palate?
 Yes No Concerned about spaced, crooked or protruding teeth?

- Yes No Aware or concerned about under or over-developed jaw?
- Yes No "Gum boils", frequent canker sores or cold sores?
- Yes No Taking any form of fluoride?
- Yes No Any relative with similar tooth or jaw relationships?
- Yes No Had periodontal (gum) treatment?
- Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated?
- Yes No Any serious trouble associated with any previous dental treatment?
- Yes No Ever had a prior orthodontic examination or treatment?
- Yes No Been under another dentist's care?
 Specialist _____
 Other _____

How often does your child Brush: _____ Floss: _____

What is your primary concern? Why are you here?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her 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: _____ Date: _____