

PATIENT INFORMATION FORM

PATIENT DETAILS

Patient's First Name _____ Patient's Last Name _____ Nickname _____
Patient's Address _____ City _____ State _____ Zip _____
Interests/Sports/Hobbies _____ Gender _____ Home Phone _____
Date of Birth _____ Age _____ Race _____ Cell Phone _____
School/Employer _____ Grade/Position _____ Work Phone _____
How did you hear about our office _____ Patient's Email _____
Family members treated in our office _____
Reason for consultation _____
Dentist _____ Date of last cleaning _____
Has the patient been examined by an orthodontist before? Yes No

GUARDIAN #1 / INSURANCE INFORMATION

Self Spouse Father Mother Stepparent Other (specify) _____
Guardian's First Name _____ Guardian's Last Name _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone _____
Date of Birth _____ Social Security Number _____ Cell Phone _____
OTHER INSURANCE (IF APPLICABLE): Guardian's E-Mail _____
Company Name _____ Phone _____ Subscriber/Member ID _____

GUARDIAN #2 / INSURANCE INFORMATION

Self Spouse Father Mother Stepparent Other (specify) _____
Guardian's First Name _____ Guardian's Last Name _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Employer _____ Work Phone _____
Date of Birth _____ Social Security Number _____ Cell Phone _____
OTHER INSURANCE (IF APPLICABLE): Guardian's E-Mail _____
Company Name _____ Phone _____ Subscriber/Member ID _____

SLEEP / AIRWAY ISSUES

Does the patient tend to be a mouthbreather? Yes No
Does the patient seem rested in the morning? Yes No
Has the patient seen an Ear, Nose & Throat Specialist? Yes No
Does the patient snore at night? Yes No
Is the patient often sleepy during the day? Yes No
Is the patient using a sleep apnea device? Yes No

DENTAL/MEDICAL HISTORY

Please check if the patient has a history of the following medical conditions:

- | | | | | | |
|--|-------------------|--|---------------------|--|----------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | ADHD/ADD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Down Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscular Disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Acid Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ear Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emotional Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Organ Transplant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocrine Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Painful Chewing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Bone Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged Bleeding |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cerebral Palsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immune Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scoliosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Clicking | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cold Sores/Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | TMJ Problems |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis |

- Yes No Do your gums bleed when you brush?
- Yes No Is the patient seeing any other dental specialists (e.g., periodontist)?
- Yes No Any dental restorations needing to be completed? What? _____
- Yes No Have there ever been any injuries to the face, mouth or chin? _____
- Yes No Have you ever lost or chipped any teeth? Which tooth/teeth? _____
- Yes No Do you have any pain or soreness around your face, neck or back? _____
- Yes No Is any part of your mouth sensitive to temperature or pressure? _____
- Yes No Is the patient currently pregnant? Due Date? _____
- Yes No Have adenoids been removed? If yes, when? _____
- Yes No Have tonsils been removed? If yes, when? _____
- Yes No Currently taking any medications? List. _____
- Yes No Are antibiotics necessary prior to treatment? List. _____
- Yes No Allergies (i.e., Drug, Latex, etc.) _____
- Yes No Any diseases or problems not mentioned above? List here. _____

Please check if the patient has, or ever had, any of the following habits?

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cheek, tongue or lip chewing | <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Finger nail biting | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Tongue sucking | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Tongue thrusting | |

SIGNED CONSENT

I understand the information given is correct and will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in the patient's medical status.

I hereby authorize this office to perform an orthodontic evaluation and consent to the taking of x-rays, photographs, and other records (if necessary) to determine appropriate treatment on the above-named patient.

I also authorize this office to leave messages about appointments on my voice mail or answering machine, and agree to receive e-mail reminders and text messages about appointments.

Typed Name/Signature _____ Relationship to Patient _____ Date _____

If someone other than the parent(s) or guardian(s) listed above will be bringing the patient to appointments, please list here: _____