ORTHODONTIC PATIENT INFORMATION

Welcome to our office.

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodonitst to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated.

Thank you.

EMAIL______________________________________

PATIENT'S NAME ____ AGE______ BIRTHDATE______________SEX______

HOME ADDRESS ____ HOME PHONE____________________

STREET CITY ZIP CODE

PATIENT'S OCCUPATION OR SCHOOL LEVEL _______________________ PATIENT'S MARITAL STATUS:_____________

PERSON RESPONSIBLE FOR ACCOUNT ____________________ HOME PHONE_____________ SS#________________

RELATIONSHIP_______________ EMPLOYER_______________ BUSINESS PHONE ______________________

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? Yes No

If YES by which company? ____

NAME OF PERSON TO BE CONTACTED IF PATIENT CANNOT BE REACHED

NAME ____ RELATIONSHIP________________________________

ADDRESS____ PHONE __________________________

FAMILY DENTIST ________________ FAMILY PHYSICIAN __________________ REFERRED BY___________________

FAMILY STATUS

SIBLINGS None ________ Number of Brothers ________ Number of Sisters

FATHER'S NAME ____________________________________ LIVING Yes No

MOTHER'S NAME ___________________________________ LIVING Yes No

OTHER FAMILY MEMBERS WITH SIMILAR ORTHODONTIC CONDITION?

Father Brother Other

Mother Sister Specify____

PATIENT LIVING WITH : Mother Father Self Other: _________________________________

MEDICAL & DENTAL HISTORY:

PRESENT HEALTH: Good Fair Poor UNDER TREATMENT: Yes No

SPECIFY: ____

PRESENT DRUGS OR MEDICATION:

SPECIFY: ____ Yes No

HAS PATIENT BEEN UNDER CARE OF A PHYSICIAN DURING THE PAST TWO

YEARS OTHER THAN FOR ROUTINE EXAMINATION? Yes No

BIRTH DEFECTS Yes No

SPECIFY: ____

HAS PATIENT REACHED PUBERTY (MENSTRUATION. HAIR)? Yes No

PLEASE FILL OUT OTHER SIDE OF FORM

The following conditions are of interest to the orthodontist.

Has the patient ever had:

AIDS	Epilepsy	Hearing Disorder
Asthma	Endocrine Problems	Head or Face Injury
Anemia	Emotional Problems	Immune Disease
Blood Disease	Glaucoma	Kidney Trouble
Bone Disease	Hepatitis	Rheumatic Fever
Diabetes	Heart Disease	

COMMENTS ____

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Does the patient:

1. Have allergies to: Seasonal grasses ______________ Food ______________
   Drugs ______________ Other ______________
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually COMMENTS: ______________
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose and throat specialist?

Yes No If YES: When ______________ By Whom ______________

Tonsils removed ______________ Adenoids removed ______________

Does the patient have pain or clicking in jaw joint? Yes No

Have any teeth been injured due to accidents or blows to the mouth? Yes No

Has the patient received or been requested to receive speech correction? Yes No

The following habits are or interest to the orthodontist. List information as it pertains to this patient:

Thumb sucking until age ______________ Grinding of teeth Yes No

Finger sucking until age ______________ Tongue thrusting Yes No

Lip-biting or sucking Yes No Other habits Yes No

Has the patient had any unusual dental experiences? Yes No

Specify: ____

Has the patient had previous orthodontic consultation or treatment? Yes No

Date: ______________________ Dr. ______________________

Are there any other medical, dental or surgical problems not covered above? Yes No

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental checkups: Twice A Year Once A Year Only If Urgent Never

Date of last dental checkup ______________ Were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problem? Yes No

Patient's interest in orthodontic treatment:

The Patient Wants Treatment Treatment If Necessary Unwilling But Agrees Uncooperative

Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse

Sibling Physician Friend Other (specify): ______________________

Why did the patient seek this consultation? ______________________

What is the primary problem? ______________________

____

What is expected from orthodontic treatment? ______________________

Additional comments you wish to make: ______________________

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SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM: ______________________

RELATIONSHIP TO PATIENT ______________________ TODAY'S DATE ______________________