PATIENT INFORMATION FORM. ***Please complete the following.***

Primary orthodontic concern:

Date ____________

Patient's Name ______ Nickname ______ Sex ______ Age ______ DOB ______

Address ______ Phone ______

School ______ Grade ______ Referred by ______

Patient's Dentist ______ Physician ______

Names and ages of other children in family ______

Marital status of parents: single ☐ married ☐ separated ☐ divorced ☐ remarried ☐ widowed ☐

Person responsible for account ______ Patient lives with: both parents ☐ mother ☐ father ☐

Address (if different from above) ______ Email address ______

Orthodontic insurance coverage? Yes ☐ No ☐ Name of Company ______ SS# ______

Father's name ______ Bus. Phone ______

Employed by ______ Occupation ______

Mother's name ______ Bus. Phone ______

Employed by ______ Occupation ______

MEDICAL HISTORY

Has the patient ever been treated for any of the following:

	Yes	No		Yes	No		Yes	No
Heart Trouble/Murmur	☐	☐	Asthma/Allergy/Hayfever	☐	☐	Immune System Problems	☐	☐
Rheumatic Fever	☐	☐	Sinus Trouble	☐	☐	AIDS/HIV	☐	☐
Hepatitis/Liver Disease	☐	☐	Fainting/Seizures	☐	☐	Cancer/Tumor	☐	☐
Respiratory Problems	☐	☐	Epilepsy	☐	☐	Abnormal Bleeding	☐	☐
Kidney Trouble	☐	☐	Diabetes	☐	☐	Anemia	☐	☐
Thyroid Problems	☐	☐	Tuberculosis	☐	☐	Nervous Disorders	☐	☐

	Yes	No
Is the patient in good health?	☐	☐
Does the patient have any history of major illness?	☐	☐
Is the patient now under the care of a physician? If so, for what reason? ______	☐	☐
Is the patient taking any medication? If so, please list them: ______	☐	☐
Does the patient have any drug allergies? If so please list them: ______	☐	☐
Has the patient had any psychological counseling?	☐	☐
Has the patient had his/her tonsils and adenoids removed? If so, at what age: ______	☐	☐
Does the patient breathe solely through the nose under normal conditions?	☐	☐
Does the patient wear contact lenses?	☐	☐
Does the patient have any condition not listed above? If so, please explain: ______	☐	☐
Growth in the last six months: ______ Has growth ceased? Yes ☐ No ☐ Has puberty been reached?	☐	☐

Height: Patient's ______ Mother's ______ Father's ______ Weight: Patient's ______ Patient resembles: Mother ☐ Father ☐ Both ☐

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? If so, please describe ______	☐	☐
Has the patient ever been informed of any missing or extra permanent teeth?	☐	☐
Have any baby or permanent teeth been removed?	☐	☐
Has the patient ever experience any of the following:		
Jaw pain during normal chewing?	☐	☐
Limited jaw movement?	☐	☐
Inability to open or close jaw completely?	☐	☐
Clicking or popping sounds in the jaw joints?	☐	☐
Tooth grinding or clenching?	☐	☐
Frequent headaches?	☐	☐
Does the patient have any speech problems?	☐	☐
Does the patient have any congenital anomalies?	☐	☐
Has the patient had a previous orthodontic examination?	☐	☐
Have either parent or other children had orthodontic treatment?	☐	☐
Does the patient want orthodontic treatment?	☐	☐
When was the patient's last dental visit? ______ Were any X-rays taken?	☐	☐
How many times a day does the patient brush his/her teeth? ______		
Has the patient ever had a thumb or finger sucking habit? If so, until what age ______	☐	☐
Please list interests, sports, and hobbies ______	☐	☐

Signature of parent or guardian ______