Welcome to the Orthodontic Practice of:

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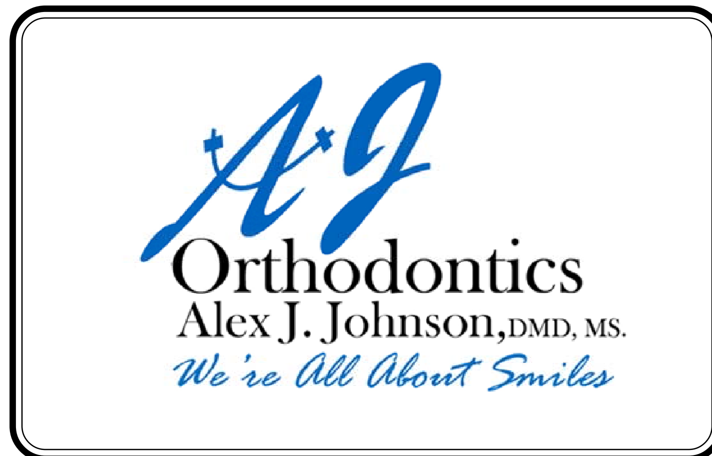


Thank you for choosing our office for your orthodontic consultation. We look forward to speaking with you and addressing your orthodontic concerns. Our goal is to provide you with the best possible care and treatment. Please carefully complete the enclosed medical and dental information so that we may be of better service to you. Thanks!

PATIENT INFORMATION

Patient's Name ______ M ______ F ______ **Today's Date** ______

Address ______ Date of Birth ______ Age ______

City ______ Zip ______ School ______ Grade ______

Patient's Physician ______ Patient's Dentist ______

Nickname ______ Phone: Home ______ Work ______

Names and ages of other children in family ______ SS# ___-___-___

Names of other family members in our orthodontic practice ______

RESPONSIBLE PARTY

Adult Patients: Please complete this form for yourself and your spouse.
Parents: If completing this form for a minor (less than 18 years of age), please complete parental information.

(Circle One)

Father / Husband / Self

Name ______ Address (if different) ______

Occupation ______ City ______ Zip ______

Employed By ______ Social Security # ______

Business Address ______ Phone: Home ______ Work ______

Drivers license # ______ Relationship to patient ______

Email Address ______

(Circle One)

Mother / Wife / Self

Name ______ Address (if different) ______

Occupation ______ City ______ Zip ______

Employed By ______ Social Security # ______

Business Address ______ Phone: Home ______ Work ______

Drivers license # ______ Relationship to patient ______

Email Address ______

MEDICAL HISTORY

YES	NO	
❑	❑	1. Is the patient presently under the care of a physician for a major illness?
❑	❑	2. Does the patient have any history of a major illness?
❑	❑	3. Is the patient in good health?
❑	❑	4. Has the patient had their tonsils (circle) or adenoids (circle) removed? What age? ______
❑	❑	If not removed, does the patient have regular problems with their tonsils or adenoids?
❑	❑	5. Female patients: Are you pregnant?
❑	❑	6. If a child: Has the patient reached puberty?
❑	❑	7. Is the patient currently taking any medications? Please list: ______
❑	❑	8. Does the patient have any physical or emotional limitations?
		9. Has the patient ever had (or have) any problems with any of the following?

YES	NO		YES	NO		YES	NO	
❑	❑	Bleeding	❑	❑	Nervous disorders	❑	❑	Bone Disorders
❑	❑	Rheumatic Fever	❑	❑	Pneumonia	❑	❑	Asthma
❑	❑	Heart Trouble	❑	❑	Anemia	❑	❑	Diabetes
❑	❑	Heart Valves	❑	❑	Fainting/Dizziness	❑	❑	Kidney Disease
❑	❑	Hemophilia	❑	❑	Liver Disease	❑	❑	Cleft Lip/Palate
❑	❑	Heart Murmur	❑	❑	Hearing	❑	❑	Epilepsy

❑ ❑ Has the patient been advised to take antibiotics prior to dental visits?

If so, by what doctor? (name and phone number) ______

10. Does the patient have or has the patient been exposed to any of the following?

YES	NO		YES	NO	
❑	❑	Hepatitis	❑	❑	HIV Positive/AIDS
❑	❑	Tuberculosis	❑	❑	Venereal Diseases

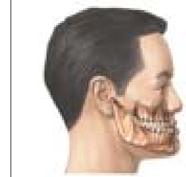
❑ ❑ 11. Does the patient have allergies to any drugs? Please list: ______

❑ ❑ 12. Does the patient have any other allergies? Please list: ______

❑ ❑ 13. Has the patient been told that they have an underbite?

❑ ❑ 14. Is there a known family history of any family member with an underbite?
If yes, what is the relationship to the patient? ______________________

Patient with Underbite



Please note: Refer back to questions 1,2,8,9,10,11 & 12. If they are answered YES, please explain below. Also, describe any other medical problems not yet covered.

❑ **No further problems to note**

______
______
______
______

DENTAL HISTORY

YES NO

❑ ❑ 14. Has there been any injuries to the face, mouth, teeth or jaw joints? When? ______

❑ ❑ 15. Does the patient have speech problems? Any previous therapy? ______

❑ ❑ 16. Has the patient ever sucked the thumb or fingers? Until what age? ______

❑ ❑ 17. Does the patient snore while sleeping?

❑ ❑ 18. Does the patient breathe through the mouth rather than the nose? ❑ Sometimes ❑ Usually

❑ ❑ 19. Has the patient ever been informed of any missing permanent teeth?

❑ ❑ 20. Has an orthodontist been previously consulted? When? ______

❑ ❑ 21. Has the patient ever had orthodontic treatment? When? ______
What treatment was rendered? ______

❑ ❑ 22. Has either parent had orthodontic treatment? Which? ______

❑ ❑ 23. Does the patient have pain in the jaw joint?

❑ ❑ 24. Does the patient have clicking in the jaw joint? How often? ______

❑ ❑ 25. Does the patient clench and/or grind the teeth?

❑ ❑ 26. Has the patient ever been diagnosed as having jaw joint (TMJ) problems? When? ______

❑ ❑ 27. Does the patient bite their fingernails?

❑ ❑ 28. Does the patient place objects (pens, pencils, etc.) in the mouth?

❑ ❑ 29. Does the patient play a contact sport? Which? ______

❑ ❑ 30. Does the patient play a musical instrument? Which? ______

❑ ❑ 31. Has the patient been seen by their dentist recently? When? ______
What was done? ______ When are they scheduled to return? ______
How often does the patient see their dentist? ______

32. Why are you seeking this consultation?

❑ To correct overbite
❑ To close spaces
❑ To straighten teeth
❑ To improve facial proportions
❑ To correct the crossbite
❑ Other *(be specific)* ______

❑ To eliminate facial pain
❑ To help clicking jaw
❑ To correct jaw problem
❑ To improve general appearance
❑ To correct an underbite

______

Please continue on to the next page

Please cover any problems or concerns not yet covered and expand on any previous questions as needed.

We always appreciate the referral of patients to our office and like to thank those who have made the referral. Whom may we thank for referring you to our office? ____________________

Thank you for choosing our office for your orthodontic consultation. Most orthodontic appointments are scheduled during school or work hours. We respect your need to be treated promptly and for this reason, we are proud of the fact that we receive our patients at their appointed time. We are able to provide this high level of service when our patients arrive on time for their appointments. Therefore, we ask that everyone arrive on time for all scheduled appointments. Please remember that if you must reschedule your appointment, kindly give us twenty-four hours advance notice.

We make a sincere effort to schedule convenient appointment times for our patients. However, it is necessary to alternate morning and afternoon appointments, particularly during the school term.

I understand that the information that I have given is correct to the best of my knowledge, and it is my responsibility to inform the office of any changes in the health status of the patient.

Authorization is hereby granted for the orthodontic consultation and any necessary dental services that the patient may have during diagnosis and treatment with my informed consent.

Date ____________________

Signature ____________________

Relationship to patient ____________________

Legal guardian *(if different)* ____________________

FOR STAFF USE ONLY

Health Alerts:

Health history reviewed by: __________ (Initial) __________ (Date)

Dr. Initial ____________________

Before: ❑ Yes ❑ No

Notes: ____________________

HEALTH HISTORY - Significant findings

Concern ____________________

Checked with ____________________

Physician ____________________

Checked by ____________________

Date ____________________

Physician RX: ____________________

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