Save Print Email Start over

Dr. Alex JOHNSON Orthodontics

For Patients Over Age 18

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

First Name	Middle Name	Last Name		Today's Date	
Nickname	Birthdate	Age	Gender	SS#	
Address		City		State	Zip
Main Phone #		2nd/Cell Phone#			
Physician		Dentist			
School	Grade	Email Address			
Who has legal custody of the patient?					

SPOUSE/PARTNER

First Name	Middle Name	Last Name	Gender	
Relationship to Patient		DOB Age	SS#	
Home Address		City	State	Zip
Main Phone #	2nd/Cell Phone#	Work Phone#		
Email Address		Work Email address		
Driver's License #				
Employer		Occupation		
Employer Address		City	State	Zip

FINANCIAL & INSURANCE

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT				
First Name	Middle Name	Last Name	Gender	
Relationship to Patient		DOB Age	SS#	
Billing Address		City	State	Zip
Main Phone #	2nd/Cell Phone#	Work Phone#		
Email Address		Work Email Address		
Driver's License #				
Employer		Occupation		
Employer Address		City	State	Zip
INSURANCE INFORMATION				
Dental Insurance Company		Phone #		
Insurance Company Address		City	State	Zip
Name of Insured	DOB	SSN/ID#	Group/Policy#	

MEDICAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Is the patient in good health?
☐	☐	☐	Presently under care of a physician for a major illness?
☐	☐	☐	Any history of a major illness?
☐	☐	☐	Cardiovascular problem (heart defects, heart murmur, heart trouble, valve issues, or rheumatic heart disease)? Cardiologist _____
☐	☐	☐	Antibiotic pre-medication needed for dental procedures?
☐	☐	☐	Rheumatic fever?
☐	☐	☐	Acid reflux issues?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Emotional issues, anxiety, or depression?
☐	☐	☐	Autism, Asperger's, or sensory issues?
☐	☐	☐	Cerebral palsy?
☐	☐	☐	Down syndrome?
☐	☐	☐	Any physical or emotional limitations?
☐	☐	☐	History of Eating Disorders/Bulimia/Anorexia?
☐	☐	☐	Seizures, Epilepsy, fainting spells, neurologic problems?
☐	☐	☐	Cancer, tumor, radiation, or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Kidney problems?
☐	☐	☐	Immune system problems?
☐	☐	☐	Excessive bleeding, bruising, anemia, or hemophilia?
☐	☐	☐	Chest pain, shortness of breath, or tire easily?
☐	☐	☐	Angina, arteriosclerosis, stroke, or heart attack?
☐	☐	☐	History of osteoporosis or osteopenia?
☐	☐	☐	Rheumatoid, osteoarthritis, or arthritic conditions?
☐	☐	☐	Bone disorders, bone fractures or major bone injuries?
☐	☐	☐	Ever taken oral or IV bisphosphonates such as Fosamax, Actonel, Boniva, Skelid, or Didronel for bone disorders?
☐	☐	☐	Vision, hearing problems, or skin disorders?
☐	☐	☐	Frequent colds, ear or throat infections?
☐	☐	☐	Asthma, sinus problems, or hay fever?
☐	☐	☐	Tonsil or adenoid issues?
☐	☐	☐	Gonorrhea, syphilis, herpes, or other STDs?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Hepatitis, jaundice, or other liver problems?
☐	☐	☐	Polio, mononucleosis, tuberculosis, or pneumonia?
☐	☐	☐	Diagnosed with ADD or ADHD?
☐	☐	☐	Poor attention span, difficulty focusing, hyperactive?
☐	☐	☐	Currently pregnant? (female patients)

If any of the above medical questions were answered 'Yes', please explain:

Any other medical conditions we should be aware of?

DENTAL HISTORY

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Concerned about under or over developed jaw?
☐	☐	☐	Concerned about spaced, crooked or protruding teeth?
☐	☐	☐	Erupting teeth very early or very late?
☐	☐	☐	Primary (baby) teeth removed that were not loose?
☐	☐	☐	Permanent or extra teeth removed?
☐	☐	☐	Supernumerary or congenitally missing teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any lost or broken fillings?
☐	☐	☐	Teeth treated with root canals or pulpotomies?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	Teeth causing irritation to lip, cheek, gums?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking or grinding noises in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Been diagnosed or treated for TMJ or TMD problems?
☐	☐	☐	Difficulty when chewing, jaw opening or TMJ issues?
☐	☐	☐	Pain, tenderness, or noise in either jaw joint?
☐	☐	☐	Neck/shoulder pain?
☐	☐	☐	Appliance for teeth grinding or jaw joint pain/noise?
☐	☐	☐	Ever been diagnosed with gum disease?
☐	☐	☐	Ever had gum treatment or surgery?
☐	☐	☐	Jaw fractures, cysts, or infections?
☐	☐	☐	Chipped, injured primary (baby) or permanent teeth?
☐	☐	☐	Prior trauma or injury to the teeth, face, or neck?
☐	☐	☐	Has an orthodontist been previously consulted?
☐	☐	☐	Has the patient ever had orthodontic treatment? (list below)
☐	☐	☐	Has either parent had orthodontic treatment?
☐	☐	☐	Does the patient play contact sports?
☐	☐	☐	Does the patient play musical instruments?
☐	☐	☐	Has the patient been seen by their dentist recently? When? _____ What was done? _____ When scheduled to return? _____ How often does the patient see the dentist? _____

If any of the above medical questions were answered 'Yes', please explain:

Please list any medications, nutritional supplements, herbal medications or non-prescription medications, including fluoride supplements that are currently being taken and what they are being taken for.

MEDICATION	REASON

AIRWAY/MYOFUNCTIONAL

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Difficulty breathing through nose? (stuffy nose)
☐	☐	☐	Mouth breathing during day? ☐ sometimes
☐	☐	☐	Mouth breathing while sleeping?
☐	☐	☐	Have a dry mouth on waking up in the morning?
☐	☐	☐	Drools while sleeping?
☐	☐	☐	Snores? ☐ occasional ☐ often ☐ routine ☐ seasonal ☐ when sick ☐ snores loudly
☐	☐	☐	Heavy or loud breathing while sleeping?
☐	☐	☐	Difficulty falling asleep or staying asleep?
☐	☐	☐	Is sleep unrefreshing or are bedsheets a mess?
☐	☐	☐	Frequently tired during the day?
☐	☐	☐	Ever had a sleep study?
☐	☐	☐	Ever been diagnosed with sleep apnea?
☐	☐	☐	Ever had myofunctional therapy?
☐	☐	☐	Oral habits, thumb, fingers, pens, pencils, other?
☐	☐	☐	Abnormal swallowing (tongue thrust)?
☐	☐	☐	History of speech problems or speech therapy? ☐ currently ☐ previously, age:

Please include any other pertinent information below:

ALLERGIES

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Seasonal allergies?
☐	☐	☐	Routine allergies?
☐	☐	☐	Local anesthetics? (novocaine, lidocaine)
☐	☐	☐	Latex allergies? (gloves, balloons)
☐	☐	☐	Antibiotics or other medications? (list below)
☐	☐	☐	Metals? (jewelry, clothing snaps)
☐	☐	☐	Acrylics?

Please include any other pertinent information below:

SURGERIES

Yes	No	dk/u	dk/u = don't know/unknown	
☐	☐	☐	Tonsillectomy?	Age:
☐	☐	☐	Adenoidectomy?	Age:
☐	☐	☐	Nasal or Sinus?	Age:
☐	☐	☐	Cleft Lip/Palate?	Age:
☐	☐	☐	Frenectomy?	Age/Type:

Please include any other pertinent information below:

GROWTH STATUS

Yes	No	dk/u	dk/u = don't know/unknown
☐	☐	☐	Has the patient grown in the past year or has their shoe size or pant length changed recently?
☐	☐	☐	Is there a known history of any family member with an underbite? If yes, what is the relationship to the patient?

Please include any other pertinent information below:

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? _____

Why are you seeking this consultation?

- ☐ to correct overbite
- ☐ to close spaces
- ☐ to straighten the teeth
- ☐ to improve facial proportions
- ☐ to improve general appearance
- ☐ to eliminate facial pain
- ☐ to help clicking jaw
- ☐ to correct jaw problem
- ☐ to correct the crossbite
- ☐ to address airway issues
- ☐ to develop the airway
- ☐ other (please be specific) _____

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. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form.

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. I authorize release of any information regarding the orthodontic treatment to my dental and/or medical insurance company.

Date _____

Signature _____ Relationship to Patient _____

Legal Guardian *(if different)* _____

FOR STAFF USE ONLY

Health Alerts

Health history reviewed by:	Staff:	Date:	Dr. initial
Before:	☐ Yes ☐ No		
Notes:			

Dental clearance	☐ NA	Date:	Doctor:
Medical clearance	☐ NA	Date:	Doctor:
Other clearance	☐ NA	Date:	Doctor:

Health History - Significant Findings Follow-up

Concern 1:	
Checked with:	
Findings:	
Staff completing task:	

Concern 2:	
Checked with:	
Findings:	
Staff completing task:	

Concern 3:	
Checked with:	
Findings:	
Staff completing task:	

Concern 4:	
Checked with:	
Findings:	
Staff completing task:	

Notes			Initial