

Welcome!

Thank you for your visit today! We are pleased to welcome you to our practice.
We look forward to working with you to maintain your dental health!

PATIENT INFORMATION

Date _____ Home Phone _____

Name _____ SSN _____

Sex Male ___ Female ___ Age ___ Date Of Birth _____

Address _____

City _____ State _____ Zip _____

Person Financially Responsible _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

Email address _____

Name _____

Address _____

Home ph. _____ Work _____

Cell _____

Employer _____

Employer address _____

City _____ Zip _____

SSN _____ DOB _____

Insurance Primary

Policy Holder _____

Company Name _____

Address _____

Phone _____

Policy# _____

Group# _____

Insurance Secondary

Policy Holder _____

Company Name _____

Address _____

Phone _____

Policy# _____

Group# _____

Medical History

Now or in the past, have you had:

Heart problems Y__N__

If yes, please specify _____

Does patient require any medication for dental procedures due to a heart problem? Y__N__

If yes, please specify _____

Birth defects or hereditary problems Y__N__

Bone fractures or major accidents Y__N__

Rheumatoid or arthritic conditions Y__N__

Endocrine or thyroid problems Y__N__

AIDS or HIV positive Y__N__

Mental health disturbance or behavioral problems Y__N__

Vision, hearing, tasting or speech issues Y__N__

Excessive bruising, anemia or bleeding disorder Y__N__

Frequent headaches, colds or sore throats Y__N__

Eye, ear, nose or throat condition Y__N__

Hayfever, asthma, sinus trouble or hives Y__N__

Tonsil or Adenoid conditions Y__N__

Fainting, seizures or epilepsy Y__N__

Any other significant medical issues: _____

Any family members with significant medical issues:

Allergies:

Please list all drug, Latex and other allergies: _____

Are you taking medication, nutrient supplements, herbal medications, or non prescription medicine?

Please specify _____

Have you had any surgeries? Y__N__

If yes, please specify _____

Have you ever been hospitalized? Y__N__

If yes, please specify _____

Being treated by another health care professional? Y__N__

Please specify _____

Primary Physician _____

Date of last physical exam _____

Results _____

Dental History

Dentist _____

Date of last exam _____

Results _____

Now or in the past, have you had:

Started teething early or late Y__N__

Primary teeth removed that were not loose Y__N__

Permanent or "extra" teeth removed Y__N__

Congenitally missing teeth Y__N__

Chipped or injured baby or permanent teeth Y__N__

Teeth sensitive to hot or cold Y__N__

Jaw fractures, cysts or mouth infections Y__N__

"Dead teeth" or root canals Y__N__

Bleeding gums, bad taste or mouth odor Y__N__

Periodontal "gum" problems Y__N__

Thumb, finger or sucking habit Y__N__

Abnormal swallowing habit (tongue thrust) Y__N__

Mouth breathing habit, snoring or difficulty breathing Y__N__

Tooth grinding, jaw clenching, clicking or locking Y__N__

Pain in jaw or ringing in ears Y__N__

Pain or soreness in muscles of the face or around the ears Y__N__

Difficulty in chewing or jaw opening Y__N__

Aware of loose, broken or missing fillings Y__N__

Taking any forms of fluoride Y__N__

Any relative with similar tooth or jaw relationships Y__N__

Periodontal "Gum" treatment Y__N__

Has patient had any trouble with previous dental treatment? Y__N__

If yes, please specify _____

Ever had a previous orthodontic exam or treatment? Y__N__

If yes, please specify _____

Been in another dentist's care Y__N__

Specialist _____

Other _____

How often does patient brush? _____ Floss? _____

What is your primary concern? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will also inform this practice. I also acknowledge receipt of privacy practices.

Signature _____

Date _____