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_____

Dental Insurance Primary
Policy Holder_____
Company Name_____
Address_____
Phone_____
Policy#_____
Group#_____

Dental 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_____

Do you require any pre-medication for dental procedures due to heart problem and/ or joint replacement **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_____