ORTHODONTIC INFORMATION RECORD

(Please Print)
TELL US ABOUT YOURSELF

Patient's Name______________________ Preferred Name______________________ Male / Female Today's Date_____________
Birthdate__________________________ SS#__________________ Email Address_______________________________________
Home Address_________________________________ City_________________________________ State _______ Zip___________
Cell Phone_________________________ Home Phone __________________________ Work Phone____________________________
Employer____ Occupation____
What is the main thing you would like to see us change about your smile? ______________________________________
____
Marital Status _______________________ Spouse (if applicable)_____________________________ Phone___________________
Emergency Contact____ Phone___________________
How did you hear about our office?____

ORTHODONTIC INSURANCE INFORMATION

Policy Holder ____ Birthdate _____/_____/_______ SS#_____________________
Relationship to Patient____________________________________ Employer____
Insurance Co. ____ Insurance Co. Phone____________________________________
Insurance Co. Address _____________________________ City ______________________________ State ______ Zip ___________
Group # ____ ID # ____

Do you have dual dental coverage? No [ ] Yes [ ] If yes, please present insurance card.

PATIENT DENTAL HISTORY

Patient's General Dentist __________________________________
Approximate last dental visit ______________________________
Clenching or grinding teeth .... No [ ] Yes [ ]
Thumb sucking/tongue thrust/other habits ... No [ ] Yes [ ]
Jaw fracture .... No [ ] Yes [ ]
Previous orthodontic treatment .... No [ ] Yes [ ]
History of mouth breathing .... No [ ] Yes [ ]
Clicking/popping in jaws .... No [ ] Yes [ ]
Treatment of gum disease .... No [ ] Yes [ ]
Recent injury to head or teeth .... No [ ] Yes [ ]

If you answered yes to any of the above please give a brief explanation: ____
____

PATIENT MEDICAL HISTORY

In good health.. No [ ] Yes [ ]
Currently taking any medication .... No [ ] Yes [ ] If so, please list: ______________________________________
Allergic to any medication .... No [ ] Yes [ ] If so, to what? ____
Currently under physician's care .... No [ ] Yes [ ] If so, for what condition? _______________________________

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

Arthritis .... No [ ] Yes [ ]
Asthma .... No [ ] Yes [ ]
Blood disorder/bleeding problems .... No [ ] Yes [ ]
Diabetes .... No [ ] Yes [ ]
Endocrine problems .... No [ ] Yes [ ]
Heart condition .... No [ ] Yes [ ]
High or low blood pressure .... No [ ] Yes [ ]
Kidney disease .... No [ ] Yes [ ]
Currently pregnant .... No [ ] Yes [ ]
Sleep-disorder /airway or sinus problems No [ ] Yes [ ]
Tuberculosis .... No [ ] Yes [ ]
Artificial bones/joints .... No [ ] Yes [ ]
Attention deficit/Hyperactivity .... No [ ] Yes [ ]
Cancer .... No [ ] Yes [ ]
Drug/ Alcohol Abuse .... No [ ] Yes [ ]
Fever Blisters/Herpes .... No [ ] Yes [ ]
Hepatitis/Liver disease .... No [ ] Yes [ ]
HIV/AIDS positive .... No [ ] Yes [ ]
Polio, mononucleosis, pneumonia............. No [ ] Yes [ ]
Psychiatric treatment .... No [ ] Yes [ ]
Speech problems .... No [ ] Yes [ ]
Ulcers/Colitis .... No [ ] Yes [ ]

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the necessary orthodontic services needed during the diagnosis and treatment with my informed consent.

Signature ____

****Please note that some orthodontic appointments will be during school/work hours.****