

Patient Name: _____ Today's Date: _____

Preferred Name: _____ Gender: _____ Date of Birth: _____ Age: _____

Email: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ School: _____ Grade: _____

Who else have we treated in your family? _____

How did you hear about our office or who referred you? _____

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Spouse or Other Parent: _____ Date of Birth: _____

Relationship to Patient: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Cell Phone: _____ Home Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Email: _____

Primary Dental Insurance

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone # _____

Member ID# _____ Group # _____ Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Name of Primary Person Covered by this Insurance: _____ SSN: _____

Insured's Mailing Address: _____ Date of Birth: _____

Insurance Company: _____ Insurance Phone # _____

Member ID# _____ Group # _____ Insured's Employer: _____

Consent to Exam

I understand that a pre-treatment exam and records are necessary before an orthodontist can make any specific treatment recommendations for my care. Pre-treatment records include a panoramic x-ray, facial and intra-oral digital photographs and a digital scan. I hereby consent to this complete orthodontic examination and to the taking of any necessary pretreatment records.

Name: _____ Signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Medical History

Primary Physician: _____ Phone: _____ Approximate date of last dental cleaning: _____

Has patient ever been under the extended care of a physician or had any surgeries? ☐ Yes ☐ No

If yes, please explain: _____

Please confirm whether or not the patient has been treated for any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Conditions (murmur, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Headaches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Infections |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Palsy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects | <input type="checkbox"/> Yes <input type="checkbox"/> No Eyesight Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Impairments |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No Autism |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ | | |

Is the patient currently on any medications? ☐ Yes ☐ No If yes, list: _____Is the patient allergic to any foods or medicines? ☐ Yes ☐ No If yes, list: _____Is the patient allergic to any plastics or metals? ☐ Yes ☐ No If yes, list: _____Is the patient taking or has the patient taken Bisphosphonates (e.g. Fosomax)? ☐ Yes ☐ NoDoes the patient need to be medicated prior to dental appointments? ☐ Yes ☐ NoHave tonsils or adenoids been removed? ☐ Yes ☐ NoAre you pregnant? ☐ Yes ☐ No**Dental and Orthodontic History**

General Dentist (name of office): _____ Approximate date of last dental cleaning _____

Is there any dental work to be completed? (Fillings, crowns, etc.). ☐ Yes ☐ No _____Have there been any injuries to the face, mouth, or teeth? ☐ Yes ☐ No _____Has the patient ever sucked their fingers or thumb? ☐ Yes ☐ No Until what age? _____Does the patient have any speech problems? ☐ Yes ☐ No _____Is the patient a mouth breather while asleep or awake? ☐ Yes ☐ No _____Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No _____Is there pain/popping/clicking in the jaw joint? ☐ Yes ☐ No When did this begin? _____Does the patient clench or grind? ☐ Yes ☐ No _____Does the patient regularly have headaches? ☐ Yes ☐ No _____Does the patient gag easily? ☐ Yes ☐ No _____Has the patient ever had orthodontic treatment? ☐ Yes ☐ No _____Has the patient ever had a previous orthodontist exam? ☐ Yes ☐ No _____Have any family members had orthodontic treatment? ☐ Yes ☐ No _____

What is the chief concern that brought you to our office? _____

I certify that the above information is complete and accurate.

Patient/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Health History Update

Patient Initial: _____ Date: _____

Doctor: _____ Date: _____