

Specialist in Orthodontics

DATE OF EXAM: \_\_\_/\_\_\_/\_\_\_

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_

PATIENT INFORMATION

AGE: \_\_\_\_\_

PATIENT'S NAME:(Last) \_\_\_\_\_ (First): \_\_\_\_\_ M.I. \_\_\_\_\_ SEX: M / F
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ HOME PH: \_\_\_\_\_
PATIENT'S DENTIST \_\_\_\_\_ WHOM CAN WE THANK FOR REFERRING YOU? \_\_\_\_\_

PART A - MINOR PATIENTS (UNDER AGE 18)

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ HOBBIES: \_\_\_\_\_ NICKNAME? \_\_\_\_\_
MOTHER \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ HOME PH: \_\_\_\_\_
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ WK PH: \_\_\_\_\_ CELL/PGR: \_\_\_\_\_
FATHER \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status \_\_\_\_\_
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ HOME PH: \_\_\_\_\_
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ WK PH: \_\_\_\_\_ CELL/PGR: \_\_\_\_\_
Names and ages of other children in family: \_\_\_\_\_

PART B - ADULT PATIENTS

EMPLOYER: \_\_\_\_\_ POSITION: \_\_\_\_\_ SS# \_\_\_\_\_
WK PH: \_\_\_\_\_ CELL: \_\_\_\_\_ PGR: \_\_\_\_\_
SPOUSE: \_\_\_\_\_ CELL: \_\_\_\_\_ PGR: \_\_\_\_\_
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ WK PH: \_\_\_\_\_ SS# \_\_\_\_\_

PART C - INSURANCE INFORMATION

INSURED NAME: \_\_\_\_\_ SS#: \_\_\_\_\_
INSURANCE COMPANY: \_\_\_\_\_ Ins. Co. Addr: \_\_\_\_\_
Do you have dual coverage?  NO  YES Group #: \_\_\_\_\_
INSURED NAME: \_\_\_\_\_ SS#: \_\_\_\_\_
INSURANCE COMPANY: \_\_\_\_\_ Ins. Co. Addr: \_\_\_\_\_

PART D - MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH?  YES  NO PATIENT'S PHYSICIAN \_\_\_\_\_ PH: \_\_\_\_\_
IS PATIENT UNDER CARE OF A PHYSICIAN?  NO  YES If yes, since when and why? \_\_\_\_\_
DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS?  NO  YES (Check appropriate responses)
 Rheumatic Fever  Anemia  Hepatitis  Diabetes  Heart Disease  Bone Disorders
 Prolonged Bleeding  Epilepsy  AIDS  Pneumonia  Nervous Disorders  Liver Disease
 Fainting & Dizziness  Cancer  Asthma  Kidney Disease  Endocrine Problems  \_\_\_\_\_

Any disease, condition or problem not listed or is there anything else we should know about your health that we have not covered in this form? \_\_\_\_\_

DOES PATIENT HAVE TENDENCY TO:  Colds  Sore Throats  Ear Infections: \_\_\_\_\_
HAVE TONSILS AND ADENOIDS BEEN REMOVED?  Yes  No
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS. \_\_\_\_\_
LIST ANY ALLERGIES OR DRUG SENSITIVITIES \_\_\_\_\_

\*(Minors Only) Height \_\_\_\_\_ Weight \_\_\_\_\_ Has the patient reached puberty?  YES  NO
Girls - Has started menstruation?  YES  NO Boys - Has voice changed?  Yes  NO

PART E - DENTAL HISTORY

APPROXIMATE DATE OF LAST DENTAL EXAM: \_\_\_/\_\_\_/\_\_\_ Were x-rays taken? YES  NO 
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? YES  NO 
HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE: \_\_\_\_\_ YES  NO 
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? YES  NO 
IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? WHILE ASLEEP? YES  NO 
HAS PATIENT BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? YES  NO 
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? YES  NO 
HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? YES  NO 
LIST ANY MUSICAL INSTRUMENTS PLAYED \_\_\_\_\_
REASON FOR CONSULTATION \_\_\_\_\_



I certify that the above information is complete and accurate.

X \_\_\_\_\_
Patient's Signature (or parent if patient is a minor)