Joseph M. Bordeaux D.D.S., M.S. Specialist in Orthodontics
WELCOME TO OUR PRACTICE

So that we might become better acquainted, please complete BOTH sides of this form and bring it with you to your appointment.

ADULT PATIENT INFORMATION

Patient's Name:_____ Preferred Name:_____ Sex: M___ F___
Home Address: _____ City:_____Zip_____
How long at this address: Years: _____ Home Telephone: _____ Cell Number: _____
Date of Birth: _____ Age: ____ E-mail: _____ Do you Smoke? Yes ___ No ___
Patient's General Dentist: _____ Phone: _____
Please describe your orthodontic problem: _____
What concerns you most about the thought of orthodontic treatment? _____
Whom may we thank for referring you to our office? _____
Other family members currently in our practice: _____
Acquaintances currently in our practice: _____

FAMILY INFORMATION

Spouse's Name: _____ Cell Number: _____
Person responsible for account: _____ Relationship to patient: _____
Home address, if different than patient: _____ City: _____
How long at this address: Years: _____ Home phone if different than patient: _____

EMPLOYMENT INFORMATION

Name: _____ Name: _____
Occupation: _____ Occupation: _____
Employer: _____ Employer: _____
Employer's Address: _____ Employer's Address: _____
Employer's Phone Number: _____ Employer's Phone Number: _____

INSURANCE INFORMATION

Subscriber's Name: _____ Subscriber's Name: _____
Relationship to Patient: _____ Relationship to Patient: _____
Date of Birth: _____ Date of Birth: _____
Social Security: _____ Social Security: _____
Dental Insurance Co.: _____ Dental Insurance Co.: _____
Group Number: _____ Group Number: _____
Insurance Phone: _____ Insurance Phone: _____

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Please see reverse

For office use only: ***Date:*** _____ ***Received by:*** _____

Your answers to the following questions will be helpful in determining an appropriate plan of treatment. All information will be kept confidential.

MEDICAL HISTORY

Physician's Name: _____ **Address:** _____

Telephone: _____

	Yes	No	
Have you experienced any health problems lately?	☐	☐	Explain:
Are you currently under a physician's care?	☐	☐	Explain:
Are you allergic to any medications?	☐	☐	Explain:
Have your tonsils or adenoids been removed?	☐	☐	List:

Current medications?	Name:	Dosage:	Purpose:
	Name:	Dosage:	Purpose:
	Name:	Dosage:	Purpose:

Please check if you have had any of the following conditions:

Anemia……	☐	Diabetes……....	☐	Heart Surgery.....	☐	Nervous/Anxious….....	☐
Asthma……	☐	Emotional Problems, etc.	☐	Hepatitis…….....	☐	Prolonged Bleeding.....	☐
Blood Disease..……	☐	Endocrine Disorders...	☐	Herpes (Fever Blisters).....	☐	Rheumatic Fever….....	☐
Bronchitis……	☐	Epilepsy…….....	☐	Hives/Rash….....	☐	Sleep Apnea…….....	☐
Bone Disorders……	☐	Frequent Headaches..	☐	Kidney Disease.....	☐	Tonsilitis……..….....	☐
Cancer……	☐	Growth Disorders….....	☐	Liver Disease.....	☐		
Developmental Disorder	☐	Heart Murmer…….....	☐	Metal Allergies.....	☐		

Is there any other condition or problem we should know about? _____

DENTAL HISTORY

Frequency of dental check-ups: ☐ **Twice a year** ☐ **Once a year** ☐ **Only if a problem exists** ☐ **Never**

** **Date of last dental cleaning with dentist:** _____ **Date of last visit with dentist:** _____

	Yes	No	
Is there any unfinished care to be completed with your dentist? ……	☐	☐	Explain: _____
Are you frightened about dental treatment?	☐	☐	Explain: _____
Have you had an unpleasant experience in a dental office?	☐	☐	Explain: _____
Have you had any facial or dental injuries?	☐	☐	Explain: _____
Have you consulted with an orthodontist previously?	☐	☐	Explain: _____
Have any teeth been removed?	☐	☐	Explain: _____
Have you had any previous orthodontic treatment?	☐	☐	Explain: _____
Are you satisfied with prior treatment?	☐	☐	Explain: _____

Please check if there is a history of:

☐ **Clenching teeth** ☐ **Muscular soreness around head and neck** ☐ **Jaw joint soreness** ☐ **Jaw joint popping**

☐ **Grinding teeth** ☐ **Headaches (more than normal)** ☐ **Jaw joint clicking** ☐ **Ringing in the ears**

☐ **Speech problems: Yes** _____ **No** _____ **Lisping: Yes** _____ **No** _____ **Mouth breathing: Awake** _____ **Asleep** _____

If yes, which sounds? _____

Is there any other information that may be helpful? _____

Signature: _____ **Date:** _____ **Reviewed By:** _____

*** **A recent cleaning and check-up (within the last 6 months) will be necessary before orthodontic appliances can be placed.**