



Date: _____

Patient Information

Patient's Name: _____

Last *First* *Middle* *Preferred Name*

Sex: Female Male Marital Status: Single Married Widowed Divorced

Address: _____

Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birthdate: _____ Age: _____ Social Security #: _____

Dentist: _____ Telephone: _____ Referred By: _____

Patient's Physician: _____ Telephone: _____

Email address: _____

Responsible Party Information

Name: _____

Last *First* *M.I.*

Marital Status: Single Married Widowed Divorced _____

Relationship to Patient

Address: _____

Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birth date: _____ Age: _____ Social Security #: _____

Employer: _____ Occupation: _____

Name: _____

Last *First* *M.I.* *Relationship to Patient*

Address: _____

Street *City* *State* *Zip*

Home Telephone: _____ Work Telephone: _____

Birth date: _____ Age: _____ Social Security #: _____

Employer: _____ Occupation: _____

Emergency Information

Contact Name: _____ Telephone: _____

MEDICAL & DENTAL HISTORY

Present Health: Good Fair Poor
Under Treatment: Yes No Specify: _____
Date of Last Dental Cleaning: _____

PRESENT DRUGS OR MEDICATION

Has patient been under care of a physician during the past two years other than for routine examinations? Yes No
Birth Defects Yes No Specify: _____
Current Medications: _____

The following conditions are of interest to the orthodontist. Has the Patient ever had:

Asthma	Yes	No	Diabetes	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Epilepsy	Yes	No	Hearing Disorder	Yes	No
Blood Disease	Yes	No	Endocrine Problems	Yes	No	Head or Face Injury	Yes	No
Bone Disorders	Yes	No	Emotional Problems	Yes	No	Rheumatic Fever	Yes	No
AIDS	Yes	No	HIV Infections	Yes	No			

Comments: _____

Does the Patient:

1. Have allergies to: Seasonal grasses: _____ Food: _____
 Drugs: _____ Other: _____
2. Snore When Sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually Comments _____
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No

Has patient received medical treatment from allergist or ear, nose, and throat specialist? Yes No

If yes: When: _____ By whom: _____

Tonsils removed: Yes No Adenoids Removed: Yes No

Have any teeth been injured due to accidents or blows to the mouth? Yes No

Has the patient received or been requested to receive speech correction? Yes No

Thumb sucking: Yes No / Until age: _____ Grinding teeth: Yes No

Finger sucking: Yes No / Until age: _____ Tongue thrusting: Yes No

Lip-biting or sucking? Yes No Other Habits: _____

Has the patient had any unusual dental experiences?

Specify: _____

Has the patient had previous orthodontic consultation or treatment? Yes No

Date: _____ Dr.: _____

Are there any other medical, dental or surgical problems not covered above? Yes No

Specify: _____

Patient:

Do you have pain in the face, neck or shoulders? Yes No

Do you have frequent headaches? Yes No

Do you have recurring tooth pain or sensitivity? Yes No

Do you have ringing, fullness or pain in your ears? Yes No

Do you have difficulty opening your mouth or does your jaw get "stuck" or "locked"? Yes No

Do your joints make noises upon opening or closure? Yes No

Do you have difficulty or pain with chewing, talking or yawning? Yes No

Do you grind or clench your teeth? Yes No

Do you have arthritis? Yes No

Have you had any previous treatment for your jaw joint (TMJ problem)? If so,

_____ When and by whom? _____

Signature: _____ **Date:** _____

-FOR COMPLETION BY THE DOCTOR

