

ORTHODONTIC PATIENT INFORMATION

First Name _____ Middle _____ Last _____ Nickname _____

Patient Address _____
City _____ Zip _____

Patient Home Phone _____

Patient's Date of Birth _____ Age _____ Gender _____

Patient's Dentist _____ Date of last visit _____ City of Dentist: _____

Referred by _____ Patient's physician _____ City of Physician _____

Please explain reasons for seeking orthodontic care _____

School _____ Grade/Year _____

Patient's interest and hobbies _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE PARENT/GUARDIAN INFO:

Patient lives with (parents, mother, father, guardian, etc...) _____

***Mother/Step-mother/(circle) Name** _____

Address if different from patient _____

Cell _____ Email Address _____

Work place _____ Occupation _____

***Father/Step-father/(circle) Name** _____

Address if different from patient _____

Cell _____ Email Address _____

Work place _____ Occupation _____

***Guardian or other step-parent/ (circle) Name** _____

Address if different from patient _____

Cell _____ Email Address _____

Work place _____ Occupation _____

***Is there a custodial parent by court order? If yes, Name** _____

Relationship to patient _____

IF THE PATIENT IS AN ADULT:

Cell _____ Email Address _____

Workplace _____ Occupation _____

QUESTIONS FOR ALL PATIENTS:

Does anyone in the family have a similar problem? Yes No Describe _____

Patient Name _____ Date _____

JAW JOINT (TMJ) HISTORY

- 1. Does the patient now have, or has the patient ever had **pain** in the jaw joints or the area of the jaw joints?..... Yes No
- 2. Does the patient now have, or has the patient ever had pain when **chewing**?... Yes No
- 3. Does the patient now have, or has the patient ever had pain when **yawning**?... Yes No
- 4. Does the patient now have, or has the patient ever had pain when **opening**?..... Yes No
- 5. Does the patient now have, or has the patient ever had **noise** in the jaw joints?..... Yes No
- 6. Does the patient now have, or has the patient ever had a **click** in the jaw joints?..... Yes No
- 7. Does the patient now have, or has the patient ever had a **pop** in the jaw joints?..... Yes No
- 8. Does the patient now have, or has the patient ever had **difficulty** opening their mouth? Yes No
- 9. Does the patient now have, or has the patient ever had the jaw become **“stuck”** or **“locked”**?..... Yes No
- 10. Does the patient **grind** their teeth?..... Yes No

DENTAL HISTORY

- 1. Does the patient now have, or has the patient ever had any problem with:
 - Sensitive, Sore, or **Bleeding gums** (gingiva)?..... Yes No
 - Bone loss** around the teeth? Yes No
 - Recession** of the gum (gingival)?..... Yes No
- 2. Has the patient ever lost or had **teeth removed**?..... Yes No
Please give teeth and reason: _____

- 3. **Does** the patient now have a **finger or thumb sucking habit**? Yes No
- 4. **Did** the patient have a finger or thumb sucking habit? To what age?_____ Yes No
Please circle any **other habits**: Nail biting, lip biting or sucking, mouth breathing, tongue thrusting, teeth clenching, teeth grinding, pencil biting
- Other:**
- 5. Does the patient now have, or has the patient ever had difficulty in **swallowing** or **chewing** foods? Yes No
- 6. Does the patient now have, or has the patient ever had any **speech** problems or speech therapy?..... Yes No
Please describe: _____

- 7. Does the patient have any **Other** special medical, jaw joint, or dental problems that have not been mentioned above?..... Yes No

MEDICAL HISTORY

Patient Name _____ Date _____

Patient's Physician _____ City _____

1. Is the patient taking any medication now?..... Yes No

Please list the medications and the purpose of the medication: _____

2. Does the patient have allergies to medications or anything else?..... Yes No

Please list the allergic items: _____

3. Has the patient ever had any hospitalizations, operations, or major illnesses?..... Yes No

Please date and describe: _____

4. Does the patient now have, or has the patient ever had frequent headaches?..... Yes No

Please date and describe: _____

5. Has the patient had any injuries to the face, mouth, teeth or jaws?..... Yes No

Please date and describe: _____

6. For women: Are you pregnant?..... Yes No

7. Does the patient now have, or has the patient ever had artificial joints placed?..... Yes No

8. Does the patient now have, or has the patient ever had rheumatic fever or rheumatic heart disease?... .. Yes No

9. Does the patient now have, or has the patient ever had any heart problems?..... Yes No

10. Does the patient now have, or has the patient ever had a heart murmur?..... Yes No

11. Does the patient now have, or has the patient ever had Tuberculosis? Yes No

12. Does the patient now have, or has the patient ever lived with someone that had Tuberculosis? Yes No

13. Has the patient ever had any problems with the healing of broken bones? Yes No

14. Does the patient now have, or has the patient ever had ear, nose, throat, or sinus problems? Yes No

Please date and describe: _____

15. Has the patient had tonsils or adenoids removed? When? _____..... Yes No

16. Does the patient now have, or has the patient ever had tubes in the ears? Yes No

17. Does the patient now have snoring at night?..... Yes No

18. Is the patient now, or has the patient ever been a mouth breather? (difficulty breathing through the nose)?

..... Yes No

19. Are the patient's lips apart often? Yes No

20. Does the patient currently, or has the patient in the past, use any tobacco products?..... Yes No
(cigarettes, snuff, cigars, chewing tobacco, or pipe) Please state the items: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party #1

Self _____ Spouse _____ Mother _____ Father _____ Other _____

Name _____ Phone () _____

Address _____

Employer _____ **Social Security Number** _____

Driver's License # _____ Date of Birth _____

Responsible Party #2

Self _____ Spouse _____ Mother _____ Father _____ Other _____

Name _____ Phone () _____

Address _____

Employer _____ **Social Security Number** _____

Driver's License # _____ Date of Birth _____

****Required for billing purposes** There cannot be financial arrangements if no SS is provided****

INSURANCE INFORMATION

INSURANCE #1

Is there orthodontic insurance? YES NO

Insurance Company Name: _____

Company Address: _____ Company Phone number: _____

ID Number: _____ Group Number: _____

Subscriber's name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

What is the Lifetime Maximum Amount for Orthodontics? _____

INSURANCE #2

Is there orthodontic insurance? YES NO

Insurance Company Name: _____

Company Address: _____ Company Phone number: _____

ID Number: _____ Group Number: _____

Subscriber's name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

What is the Lifetime Maximum Amount for Orthodontics? _____

THERE IS A 90 DAY SERVICE WINDOW FOR NEW INSURANCE

Required information to submit insurance

Due to HIPPA laws we are unable to accept personal information via text or email