

WELCOME TO OUR OFFICE

SO THAT WE MIGHT BECOME BETTER ACQUAINTED, PLEASE COMPLETE THE FOLLOWING:

Today's Date _____

YOUR NAME: _____ Birth date _____ Age _____

Home Address _____ City _____ Zip _____ Home Phone _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name _____ Occupation _____

Business Address _____ Business Phone _____

Person Responsible for Account _____

If Dental Insurance, Name of Carrier _____ Do They Provide Orthodontic Benefits? Yes No Not Sure

Relatives or Friends Treated Here _____

Who referred you, or how did you find out about our office? _____

Medical History

Patient's Physician _____ City _____

CHECK ANY OF THE FOLLOWING FOR WHICH YOU HAVE BEEN TREATED:

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eye or ear problem | <input type="checkbox"/> Hepatitis or liver disease |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prolonged bleeding |
| <input type="checkbox"/> Heart disease or murmur | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous disorders |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Asthma or hay fever | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Bone disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |

Currently under treatment for: _____

Medications now being taken: _____

List an allergies or drug sensitivity: _____

Have tonsils and/or adenoids been removed? Yes No If yes, at what age? _____

Dental History

Patient's Dentist _____ City _____

Approximate Date of Last Dental Visit _____ Reason _____

CHECK ANY OF THE FOLLOWING THAT APPLY:

Comments

- | | |
|---|-------|
| <input type="checkbox"/> Any injury or operation to face, mouth, or teeth? | _____ |
| <input type="checkbox"/> Have you ever sucked your thumb or fingers? Until what age? | _____ |
| <input type="checkbox"/> Do you grind or clench your teeth during day or night? | _____ |
| <input type="checkbox"/> Do you have any speech difficulty? | _____ |
| <input type="checkbox"/> Do you have any difficulty chewing? | _____ |
| <input type="checkbox"/> Teeth difficult to clean? | _____ |
| <input type="checkbox"/> Awareness of any gum or bone problem around teeth? | _____ |
| <input type="checkbox"/> Pain or noise from jaw joint? | _____ |
| <input type="checkbox"/> Inability to open mouth wide or move jaw normally? | _____ |
| <input type="checkbox"/> Prior orthodontic work or consultation with an orthodontist? | _____ |
| <input type="checkbox"/> Concerned about the appearance of your teeth? | _____ |

What is the primary reason you are seeking an orthodontic examination? _____

Signature _____

Thank You