



ORTHODONTICS

Patient's Name Ms. Miss Mrs. Mr. _____
 First M.I. Last Prefer To Be Called

Birthdate _____ Age _____ Sex _____ School (if applicable) _____ Grade _____
 Mo. Day Year

Patient's Physician _____ Interests _____

Patient's Dentist _____ Last Visit _____ For _____

Medical History Form

Please answer the following:

CHECK ONE
 Yes No

1. Is the patient in good health? _____
2. Has the patient had any history of hay fever, rheumatic fever, hepatitis, high blood pressure, epilepsy, cerebral palsy, heart trouble, allergies, diabetes, asthma, kidney, liver or blood disorders, (If yes underline condition) for which he or she has received treatment or medicine AIDS or HIV infection _____
3. Has the patient had an unfavorable reaction to drugs, including antibiotics and local anesthetic solution? If so, please specify. _____
4. Has the patient had surgery? If so, please specify. _____
5. Is the patient presently taking any medications? If so, what? _____
6. Has the patient had any history of thumbsucking, fingersucking, lip biting, nail biting, speech problems? (If so, underline condition) _____
7. Has the patient had any unfavorable experience in a dental or medical office? (If so, underline which) _____
8. Do you consider the patient to be high-strung or generally nervous? _____
9. Is the patient mentally or emotionally handicapped? _____
10. Is the patient a mouth breather? While awake? _____ While asleep? _____
11. Has the patient been informed of any missing or extra permanent teeth? _____
12. Has the patient experienced any problems or pain with the muscles or joints of his jaws? _____
13. Any baby or permanent teeth removed by your dentist? _____
14. Any traumatic injuries to the teeth, face or jaws? _____
15. Has the patient ever been treated for or been told they have periodontal disease (Pyorrhea)? _____
16. Has the patient ever been examined by an orthodontist before? _____ When? _____
17. Has the patient ever worn braces or retainers? _____ Describe _____
18. Has any member of your family received orthodontic treatment? _____
19. If we have treated a family member or close friend, please name: _____
20. Women — Are you pregnant? _____
- If under 18:
 21. Onset of Puberty: (boys-voice changed; girls-started menstruation) Yes _____ When _____ No _____
 22. Number of brothers and sisters and ages _____
 23. Is your child adopted? _____ If so, is he/she aware? _____
24. In your own words, what is the problem? _____

If the patient is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental service can be started and accomplished by the doctor.

Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Thank you for your cooperation. The above information is important in the diagnosis and treatment of the patient and will be kept in strict confidence.

Signed _____
 Patient, Parent or Guardian

Date _____

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Date _____

Confidential Responsible Party Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes If yes:

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____