

PATIENT INFORMATION FORM



PATIENT INFORMATION

Name: _____ Gender: _____
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: _____ Age: _____ SS#: _____ Occupation: _____
Employer: _____ # of Years Employed: _____
Work #: _____ Home #: _____ Cell #: _____
E-Mail Address: _____
Hobbies/Sports: _____
School: _____ City of School: _____
Other family members seen by us (provide age): _____
Sibling(s) not listed above (current or treated elsewhere): _____
Whom may we thank for referring you to our office? _____
Dentist's Name: _____ City: _____ Phone #: _____ Last Visit: _____

Responsible Party's Signature: _____ Today's Date: _____

INSURANCE

INSURANCE: If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance AS A COURTESY for any future treatment, insurance information must be **filled out completely BEFORE** you come in for your Initial appointment (Note: Orthodontics is Dental and TMJ is Medical)

Do you have Orthodontic Insurance? ___ No ___ Yes Carrier: _____ Member ID#: _____
Carrier Address: _____ Carrier Ph#: _____
Name of Primary Insured: _____ Primary Birthdate: _____ Primary SS#: _____
Do you have Secondary Insurance? ___ No ___ Yes Carrier: _____ Member ID#: _____
Carrier Address: _____ Carrier Ph#: _____
Name of Secondary Insured: _____ Secondary Birthdate: _____ Secondary SS#: _____

RESPONSIBLE PARTY

NOTE: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the **only person** legally able to acquire Information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: _____ Relationship to Patient: _____
Employer: _____ Occupation: _____ #of Years Employed: _____
Home#: _____ Cell#: _____ SS#: _____ Birthdate: _____
Billing Address: _____
Previous Address (if less than 3 years): _____
Mother's Information: Step Mother Guardian Name: _____ Birthdate: _____
SS#: _____ Home #: _____ Cell #: _____
Father's Information: Step Father Guardian Name: _____ Birthdate: _____
SS#: _____ Home #: _____ Cell #: _____
Who is Responsible for Making Appointments? Name: _____
Relationship to Patient: _____ Home #: _____ Cell #: _____

If you are **NOT** the **Patient** or the **Responsible Party** filling out this form, please provide:

Name: _____ Relationship to Patient: _____
Address: _____ Home #: _____ Cell #: _____

Responsible Party's Signature: _____ Today's Date: _____

EMERGENCY

Primary Physician's Name: _____ Phone#: _____
Physician's Address: _____ City: _____
Name of nearest relative NOT living with you: _____
Address: _____
Home #: _____ Work #: _____ Cell #: _____

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE



DATE: _____

NAME: _____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parent's main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Facial Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Gum Disease/ Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Gum Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Jaw Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Jaw Joint Sounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ringing or "Stuffly" Ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bad Bite			
<input type="checkbox"/> "Buck" Teeth/ Overjet			
<input type="checkbox"/> Crowding of Upper Teeth			
<input type="checkbox"/> Crowding of Lower Teeth			
<input type="checkbox"/> Crowding of Upper and Lower Teeth			
<input type="checkbox"/> Crossbite			
<input type="checkbox"/> Dentist Recommended Seeing an Orthodontist			
<input type="checkbox"/> Grinding Teeth			
<input type="checkbox"/> Gummy Smile			
<input type="checkbox"/> Impacted Tooth/ Teeth			
<input type="checkbox"/> Improper Tooth Position			
<input type="checkbox"/> Irregular Shaped Tooth/ Teeth			
<input type="checkbox"/> Missing Tooth /Teeth			
<input type="checkbox"/> Mouth Too Small			
<input type="checkbox"/> Open Bite			
<input type="checkbox"/> Prominent Low Jaw (too "strong")			
<input type="checkbox"/> Protrusion of Teeth			
<input type="checkbox"/> Recessive Lower Jaw (too "weak")			
<input type="checkbox"/> Rotations			
<input type="checkbox"/> Small Teeth			
<input type="checkbox"/> Spaces			
<input type="checkbox"/> Thumb/ Finger Habit			
<input type="checkbox"/> Underbite			
<input type="checkbox"/> OTHER _____			

B. Family members with similar problems:

- Father
- Mother
- Brother
- Sister
- OTHER _____

II. MEDICAL DENTAL HISTORY

A. Present Health

	Good	Fair	Poor
1. Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Under Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Has the patient reached puberty? Yes No

C. Has the patient ever had any of the following conditions?

- Allergies
- AIDS / ARC / HIV (Circle)
- Arteriosclerosis
- Asthma
- Autoimmune Disorder
- Blood Disease
- Bone Disorder
- Cancer
- Diabetes
- Dizziness
- Emotional Problems
- Endocrine Problems
- Epilepsy
- Female Problems
- Frequent Headaches
- Glaucoma
- Hay Fever
- Hearing Disorders
- Heart Disease / Surgery
- Hepatitis
- Herpes / Fever Blisters
- High Blood Pressure / Low Blood Pressure (Circle)
- Hospitalized for Any Reason
- Kidney Disease
- Lupus
- Mitral Valve Prolapse
- Pacemaker
- Psychiatric Problems
- Radiation Treatment
- Rheumatic Fever
- Ringing of Ears
- Seizures
- Sinus Problems
- Sleep Disturbance
- Stroke
- Thyroid Problems
- Trauma (to face, teeth, jaws or head)
- Tuberculosis
- Ulcers
- Venereal Disease
- _____

D. Medications (Current medications taken by patient):

- Antibiotics
- Birth Control Pills
- Diet Pills (Diuretics)
- Heart Pills (Digitalis, etc.)
- Insulin
- Muscle Relaxants (Valium, etc.)
- Pain Pills (Demerol, Codeine, etc.)
- Sleeping Pills
- Tranquilizers (Elavil, Valium, etc.)
- Vitamins
- OTHER _____

E. Allergies to Medications/Food (The patient demonstrates an allergic response to):

- Antibiotics (specifically) _____
- Aspirin
- Codeine
- Dairy Products
- Dental Anesthetics
- Erythromycin
- Food Dyes
- Jewelry / Metals
- Latex
- Pain Pills (specifically) _____
- Wheat
- OTHER _____

F. Other Pertinent Information (Has the patient ever had a history of the following?):

1. Other Habits
2. Colds
3. Difficulty Chewing
4. Difficulty Swallowing
5. Finger Sucking
6. Grinding Teeth
7. Headaches
8. Lip Biting
9. Mouth Breathing
10. Pain in Jaw Joint
11. Smoking
12. Snoring
13. Sore Teeth
14. Sore Throats
15. Speech Problems
16. Thumb Sucking
17. Tongue Thrusting
18. Tonsillitis
19. OTHER _____

C. Orthodontic consultation was prompted by:

- Patient (Name) _____
- Dentist (Name) _____
- Spouse
- Mother / Father / Brother / Sister (Circle)
- Other relative (Name) _____
- Friend (Name) _____
- OTHER _____

D. Has the patient ever had any unusual dental experience?

- No _____
- Yes If yes, please explain: _____

E. Are there any medical, dental, surgical or psychological problems not covered above?

- No _____
- Yes If yes, please explain: _____

F. Has the patient ever had a previous orthodontic consultation/treatment?

- No _____
- Yes If yes, please explain: _____

G. Health Professional(s) (Current or have seen previously)

- Doctor Name: _____
Reason(s) for treatment: _____
Doctor Name: _____
Reason(s) for treatment: _____
Doctor Name: _____
Reason(s) for treatment: _____

H. Why are you seeking this consultation?

- To improve dental appearance
- To improve facial appearance
- To improve general appearance
- To improve longevity of teeth
- To improve self-esteem
- To reduce facial pain
- To reduce headaches/neck aches
- OTHER _____

Comments:

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

III. PATIENT'S OR PARENT'S ATTITUDE TOWARD TEETH CARE AND ORTHODONTIC TREATMENT

A. Regular dental checkups:

- Twice a year
- Once a year
- Only if necessary
- Never

B. Patient's interest in orthodontic treatment:

- Eager for treatment
- Willing if necessary
- Dreading but agrees
- Unwilling

Patient/Responsible Party's Signature Date

Orthodontist/General Dentist's Signature Date

