## *PATIENT HISTORY FORM*

EXAM DATE ___/___/___

| Patients Name | Age | Sex | Adopted? Yes___ No___ | Birth Date ___/___/___ |
|---|---|---|---|---|
| Address | City | | Zip | Home Phone |
| School/Employer | | Grade/ Position | | Dentist: |
| Comments (Are you experiencing any pain or discomfort?) | | | | |
| Father or Husband | | | Cell Phone | Marital Status |
| Address | | | | Home Phone |
| Employer | | Position | | Work Phone |
| Mother or Wife | | | Cell Phone | Marital Status |
| Address | | | | Home Phone |
| Employer | | Position | | Work Phone |
| In case of Emergency,Contact: | | | Phone | Relationship to Patient |

| Siblings:Name/Age | Name/Age | Name/Age | Name/Age | Name/Age |
|---|---|---|---|---|

## *GENERAL INFORMATION*

| What would you like to change about your smile and or face or profile | | | Who first noticed the problem? | Pt___ M___ F___ Dentist___ Other___ |
|---|---|---|---|---|
| Are you self conscious of your teeth? | Very___ | Moderate___ | Unconcerned___ | Musical Instruments: |
| Attitude toward wearing braces: | Eager___ | Resigned___ | Indifferent___ Opposed___ | Sports: |
| How often do you brush your teeth: In the morning___ | After Lunch___ | After Dinner___ | Before Bed___ | Interests: |
| Do you have any questions about orthodontic treatment? | | | | |
| What special attention would be effective in working with the patient? | | | | |
| Are you aware that the success of orthodontic treatment is heavily dependent upon the degree of cooperation received? | Yes___ | No___ | | |
| WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? | | | | |
| Responsible Party Email Address: | | | | |

Preferred means of appt. confirmation or notification: Email Home Phone Dad Work Mom Work Dad Mobile Mom Mobile

## *DENTAL HISTORY*

| Name of Attending Dentist: | | | Date of Last Visit: ___/___/___ |
|---|---|---|---|
| Address: | City | Zip | Phone |

HAVE YOU EVER EXPERIENCED ANY DENTAL OR FACIAL TRAUMA? Please explain

ARE YOU EXPERIENCING ANY PAIN OR DISCOMFORT IN THE TEETH, HEAD OR NECK? Please explain

HAVE YOU EVER HAD SURGERY INVOLVING THE HEAD, FACE, NECK, MOUTH OR TEETH? Please explain

HAVE ANY OF YOUR TEETH EVER BEEN BROKEN, LOOSE OR KNOCKED OUT? Please explain

| DO YOU HAVE ANY JAW JOINT (TMJ) PROBLEMS? Circle any that apply | |
|---|---|
| Locking | Discomfort in Opening or Closing |
| Pain | Clenching or Grinding |
| Clicking or Popping | Frequent Headaches |

| Do you have any of the following oral problems? Circle any that apply | |
|---|---|
| Canker/ Cold Sores | Mouthbreathing: Day Night |
| Swollen/ Bleeding Gums | Tonsils and/or Adenoids Removed? Yes No |
| Thumb or Finger Sucking Habits | Dificulty in Chewing or Swallowing Food |

HAVE ANY SIBLINGS HAD ORTHODONTICS? If so, please state stage and type of treatment

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT?
Mother
Father
RESULTS?

DOES ANYONE ELSE IN THE FAMILY HAVE A SIMILAR DENTOFACIAL CONDITION? explain
Crowded, retruded, or protruded teeth?
Protruding lower jaw
Receding chin

HAVE YOU HAD ANY PREVIOUS ORTHODONTIC TREATMENT/CONSULTATION?
Orthodontist:
Outcome:

## *FINANCIAL INFORMATION* ***(All information is confidential, and will be shared only with the Carrier to obtain your maximum benefit)***

| Personal responsible for account | | | Relationship to patient? |
|---|---|---|---|
| Address where statements should be sent | | How long at this address? | Gaurantor's Phone |
| Primary Insurance Carrier | Subscriber Name | Subscriber Date of Birth | Subscriber SS# or Ins. ID# |
| Subscriber Employment Status: circle one<br>Full Time Part Time Other | Group # | Plan | |
| Employer | | Employer Address | Employer Phone |
| Human Resources Contact | Union Local # if applicable | Employer Alternate Phone | Employer Fax |

| Carrier Address | Carrier Phone | Carrier Fax | Contact |
| --- | --- | --- | --- |
| | | | |