PATIENT and HEALTH HISTORY INFORMATION

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone_____ Birth Date_____ Social Security #_____

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

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

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Birth Date_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed_____

Birth Date _____ Work Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name and address of emergency contact _____

Phone _____

MEDICAL HISTORY

Physician _____

Date of Last Visit _____

Address _____

Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have you seen a physician in the last 12 months? Why? _____

Please circle Yes or No for any medical condition that you have had or currently have:

Yes No Abnormal bleeding/Hemophilia
Yes No Anemia
Yes No Arthritis
Yes No Asthma or Hayfever
Yes No Bone Disorders
Yes No Congenital Heart Defect
Yes No Diabetes
Yes No Dizziness
Yes No Epilepsy
Yes No Gastrointestinal Disorders
Yes No Heart Murmur
Yes No Heart Problems
Yes No Hepatitis/Liver Problems
Yes No Herpes
Yes No High Blood Pressure
Yes No HIV/Aids
Yes No Kidney Problems
Yes No Nervous Disorders
Yes No Pneumonia
Yes No Prolonged Bleeding
Yes No Radiation/Chemotherapy
Yes No Rheumatic Fever
Yes No Tuberculosis
Yes No Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

_____

_____

_____

DENTAL HISTORY

General Dentist _____

Date of last visit _____

Address _____

Phone _____

What concerns you most about your teeth? _____

Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have "tension" headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____

Female Patients only:
Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

There are some appointments that will need to be completed during school/work hours.
Please list some hobbies or interests _____

BENEFITS of ORTHODONTIC TREATMENT

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Wells to perform a complete orthodontic evaluation.

Signature: _____ Date: _____