# PATIENT INFORMATION FORM

EXAM DATE ____/____/____ (MM / DD / YYY)

PATIENT NAME _____ (LAST / FIRST / INITIAL) ☐Mr. ☐Miss ☐Ms. ☐Mrs. ☐Dr. DATE OF BIRTH ____/____/____ (MM / DD / YYY)

ADDRESS _____ CITY _____ POSTAL CODE _____

PHONE NUMBER _____ E-MAIL _____ AGE _____ SEX _____

PATIENT LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ FOSTER HOME ☐ OTHER _____

FATHER'S NAME _____ MOTHERS'S NAME _____

EMPLOYED BY _____ EMPLOYED BY _____

BUS. TELEPHONE _____ BUS. TELEPHONE _____

PARENT'S MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ REMARRIED ☐ WIDOW(ER)

PATIENT'S DENTIST _____ PHYSICIAN _____

PERSON RESPONSIBLE FOR ACCOUNT _____

DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? ☐ YES ☐ NO ☐ ?

IF YES, FILL OUT THE ATTACHED INSURANCE INFORMATION FORM.

WHOM MAY WE THANK FOR REFERRING YOU? ☐ DENTIST ☐ PHONEBOOK ☐ FRIEND ☐ RELATIVE ☐ INTERNET ☐ OTHER _____

LIST ANY FAMILY MEMBERS THAT ARE PATIENTS IN OUR OFFICE _____

WHAT IS YOUR CHIEF CONCERN? WHAT BROUGHT YOU HERE? PLEASE BE SPECIFIC

## MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU EVER HAD:

| YES | NO | | YES | NO | | YES | NO | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ALZHEIMER'S DISEASE | ☐ | ☐ | EXCESSIVE THIRST | ☐ | ☐ | PERSISTENT COUGHING |
| ☐ | ☐ | ANAPHYLAXIS | ☐ | ☐ | FAINTING SPELLS/DIZZINESS | ☐ | ☐ | PNEUMONIA |
| ☐ | ☐ | ANEMIA | ☐ | ☐ | FREQUENT DIARRHEA | ☐ | ☐ | PROLONGED BLEEDING |
| ☐ | ☐ | ANGINA | ☐ | ☐ | GLAND PROBLEMS | ☐ | ☐ | PSYCHIATRIC CARE |
| ☐ | ☐ | ARTHRITIS | ☐ | ☐ | GLAUCOMA | ☐ | ☐ | RADIATION TREATMENTS |
| ☐ | ☐ | ARTIFICIAL HEART VALVE | ☐ | ☐ | HAY FEVER | ☐ | ☐ | RECENT WEIGHT LOSS |
| ☐ | ☐ | ARTIFICIAL JOINT | ☐ | ☐ | HEART ATTACK/FAILURE | ☐ | ☐ | RENAL DIALYSIS |
| ☐ | ☐ | ASTHMA | ☐ | ☐ | HEART DISEASE | ☐ | ☐ | RHEUMATIC FEVER |
| ☐ | ☐ | BLOOD DISEASE | ☐ | ☐ | HEART MURMUR | ☐ | ☐ | RHEUMATISM |
| ☐ | ☐ | BLOOD TRANSFUSION | ☐ | ☐ | HEART PACE MAKER | ☐ | ☐ | SCARLET FEVER |
| ☐ | ☐ | BONE DISORDER | ☐ | ☐ | HEMOPHILIA | ☐ | ☐ | SHINGLES |
| ☐ | ☐ | BRUISE EASILY | ☐ | ☐ | HEPATITIS | ☐ | ☐ | SICKLE CELL DISEASE |
| ☐ | ☐ | CANCER | ☐ | ☐ | HIGH BLOOD PRESSURE | ☐ | ☐ | SINUS TROUBLE |
| ☐ | ☐ | CHEMOTHERAPY | ☐ | ☐ | HIVES OR RASH | ☐ | ☐ | SPINA BIFIDA |
| ☐ | ☐ | CHEST PAINS | ☐ | ☐ | HYPOGLYCEMIA | ☐ | ☐ | STOMACH DISORDER |
| ☐ | ☐ | CONVULSIONS | ☐ | ☐ | IMMUNE DEFICIENCY (HIV/AIDS) | ☐ | ☐ | STROKE |
| ☐ | ☐ | CORTISONE MEDICINE | ☐ | ☐ | IRREGULAR HEARTBEAT | ☐ | ☐ | SWELLING OF LIMBS |
| ☐ | ☐ | DO YOU SMOKE OR USE SMOKLESS TOBACCO? | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ | THYROID DISEASE |
| ☐ | ☐ | DIABETES | ☐ | ☐ | LEUKEMIA | ☐ | ☐ | TONSILLITIS |
| ☐ | ☐ | DRUG ABUSE | ☐ | ☐ | LIVER DISEASE | ☐ | ☐ | TUBERCULOSIS |
| ☐ | ☐ | EASILY WINDED | ☐ | ☐ | LUNG DISEASE | ☐ | ☐ | TUMORS OR GROWTHS |
| ☐ | ☐ | EMOTIONAL DISORDER | ☐ | ☐ | LOW BLOOD PRESSURE | ☐ | ☐ | ULCERS |
| ☐ | ☐ | EMPHYSEMA | ☐ | ☐ | MITRAL VALVE PROLAPSE | ☐ | ☐ | VENEREAL DISEASE |
| ☐ | ☐ | EPILEPSY | ☐ | ☐ | PARATHYROID DISEASE | ☐ | ☐ | YELLOW JAUNDICE |

YES NO

☐ ☐ DO YOU HAVE OR HAVE YOU EVER HAD ANY DISEASES, CONDITIONS, OR PROBLEMS NOT LISTED ABOVE? SPECIFY:

WHAT IS YOUR PRESENT HEALTH? ☐ GOOD ☐ FAIR ☐ POOR

☐ ☐ ARE YOU PRESENTLY TAKING ANY MEDICATIONS OR DRUGS? SPECIFY:

☐ ☐ DO YOU HAVE ANY ALLERGIES OR DRUG SENSITIVITY? SPECIFY:

☐ ☐ IS YOUR PHYSICIAN CURRENTLY TREATING YOU FOR ANY CONDITIONS?

☐ ☐ DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS OR OPERATIONS? SPECIFY:

TURN OVER

☐ ☐ HAVE YOU HAD TONSILS OR ADENOIDS REMOVED? AT WHAT AGE?_____

THE FOLLOWING QUESTIONS HAVE TO DO WITH GROWTH:

☐ ☐ GIRLS - HAVE YOU STARTED MENSTRUATION? AT WHAT AGE? _____ ARE YOU TAKING CONTRACEPTIVES? ☐ YES ☐ NO

☐ ☐ BOYS-HAS YOUR VOICE CHANGED?

PARENTS' HEIGHT: MOTHER _____ FATHER _____

LIST SPORTS, HOBBIES AND INTERESTS _____

## DENTAL HISTORY

HAVE YOU HAD PREVIOUS ORTHODONTIC CARE OR CONSULTATION? ☐ YES ☐ NO

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:

| YES | NO | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | ANY INJURIES TO THE: | ☐ FACE | ☐ MOUTH | ☐ TEETH |
| ☐ | ☐ | TOOTHACHE | | | |
| ☐ | ☐ | TEETH SENSITIVE TO | ☐ HOT | ☐ COLD | |
| ☐ | ☐ | GUM DISEASE | | | |
| ☐ | ☐ | LUMPS OR SORES IN MOUTH | | | |
| ☐ | ☐ | HERPES/APTHOUS ULCERS | | | |
| ☐ | ☐ | SPEECH PROBLEMS? | | | |
| ☐ | ☐ | HAVE YOU EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? _____ | | | |
| ☐ | ☐ | ARE YOU A MOUTH BREATHER? | ☐ WHILE AWAKE | ☐ WHILE A SLEEP | |
| ☐ | ☐ | ARE YOU AWARE OF ANY : | ☐ MISSING TEETH | ☐ EXTRA PERMANENT TEETH | |

HAVE YOU EVER HAD ANY PROBLEMS OR SIDE EFFECTS ASSOCIATED WITH PREVIOUS DENTAL CARE? ☐ YES ☐ NO

WHEN DID YOU LAST HAVE DENTAL EXAM AND CLEANING? _____

ARE THERE ANY FILLINGS/CROWNS STILL TO BE DONE? ☐ YES ☐ NO IS THE APPOINTMENT SCHEDULED? ☐ YES ☐ NO

IF YES, DATE: _____

## TMJ

| YES | NO | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | DO YOU CLENCH OR GRIND YOUR TEETH? | | | | | |
| ☐ | ☐ | DO YOU EVER HEAR: | ☐ CLICKING | ☐ GRINDING SOUNDS IN YOUR JAW JOINT? | | ☐ LEFT | ☐ RIGHT |
| ☐ | ☐ | HAVE YOUR JAWS EVER LOCKED: | ☐ OPEN? | ☐ CLOSED? | | | |
| ☐ | ☐ | DO YOU GET FREQUENT: | ☐ HEADACHES? | ☐ SORE FACIAL MUSCLES? | | | |

☐ ☐ DO YOU WANT ORTHODONTIC TREATMENT IF INDICATED?

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

## OFFICE USE ONLY

TC NOTES _____

CLINICAL OBSERVATIONS _____

ESTIMATED: COST _____

TIME _____

PROVISIONAL TREATMENT PLAN _____