

**ORTHODONTIC HISTORY FORM**

Patient's Name \_\_\_\_\_ Sex: [ ]M [ ]F Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_ Home phone \_\_\_\_-\_\_\_\_-\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip Code \_\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell # \_\_\_\_-\_\_\_\_-\_\_\_\_

If child, responsible party: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Patient's martial status (Parents if Minor): [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed

**INSURANCE INFORMATION:**

Do you have dental insurance? YES NO Dental Insurance Company \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_

Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Policy # \_\_\_\_\_

**Please check appropriate answers:**

**CHECK ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

**ALLERGIES:**

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Health pills (digitalis, etc) | <input type="checkbox"/> Antibiotics         | <input type="checkbox"/> Aspirin     | <input type="checkbox"/> Barbiturates/sleeping pills |
| <input type="checkbox"/> Diet pills (diuretics)        | <input type="checkbox"/> Pain pills          | <input type="checkbox"/> Codeine     | <input type="checkbox"/> Iodine/Metals               |
| <input type="checkbox"/> Vitamins                      | <input type="checkbox"/> Birth Control pills | <input type="checkbox"/> Latex       | <input type="checkbox"/> Local anesthetic            |
| <input type="checkbox"/> Sleeping pills                | <input type="checkbox"/> Muscle relaxants    | <input type="checkbox"/> Food Dyes   | <input type="checkbox"/> Antibiotics _____           |
| <input type="checkbox"/> Insulin                       | <input type="checkbox"/> Other               | <input type="checkbox"/> Sulfa       | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Anti-Osteoporosis             | <input type="checkbox"/> <b>NONE</b>         | <input type="checkbox"/> Wheat/Diary | <input type="checkbox"/> <b>NONE</b>                 |

**MEDICAL CONDITIONS:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Sleep disturbance        |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Tattoos/body piercing    |
| <input type="checkbox"/> Arteriosclerosis    | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> HIV positive            | <input type="checkbox"/> Transfusion              |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Kidney problems         | <input type="checkbox"/> Transplant               |
| <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Psychiatric treatment   | <input type="checkbox"/> Trauma to teeth/face/jaw |
| <input type="checkbox"/> Blood disease       | <input type="checkbox"/> Female problems    | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Bone disorder       | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Ringing of the ears     | <input type="checkbox"/> <b>NONE</b>              |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Sinus problems          |   |

**WHAT ARE THE PATIENTS/PARENTS MAIN CONCERNS REGARDING THE JAW AND TEETH:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> "Buck" teeth       | <input type="checkbox"/> Headaches/facial pain        | <input type="checkbox"/> Missing teeth   | <input type="checkbox"/> Protrusion of teeth        |
| <input type="checkbox"/> Clicking jaw joint | <input type="checkbox"/> Irregularly shaped teeth     | <input type="checkbox"/> Mouth too small | <input type="checkbox"/> Receded jaw                |
| <input type="checkbox"/> Crowding           | <input type="checkbox"/> Irregular facial proportions | <input type="checkbox"/> Neck pain       | <input type="checkbox"/> Ringing/Stuffiness of ears |
| <input type="checkbox"/> Gum disease        | <input type="checkbox"/> Jaw dysfunction              | <input type="checkbox"/> Over-bite       | <input type="checkbox"/> Spaces                     |
| <input type="checkbox"/> Gummy smile        | <input type="checkbox"/> Jaw pain                     | <input type="checkbox"/> Prominent jaw   | <input type="checkbox"/> Other _____                |

**PLEASE CHECK ALL THAT APPLY TO THE PATIENT:**

- Frequent colds
- Sore throats/tonsillitis
- Difficulty swallowing
- Difficulty chewing
- NONE**
- Clicking in jaw joint
- Lip biting or sucking
- Tongue thrusting
- Snoring
- Other habits \_\_\_\_\_
- Speech problems
- Grinding of teeth
- Smoking
- Pain in jaw joint
- Drink more than one glass of milk per day

- Thumb sucking:  Never  Previous  Presently
- Finger sucking:  Never  Previous  Presently
- Breath through mouth:  Seldom  Sometimes  Usually
- Dental Checkups:  Twice a year  Once a year  Only if urgent  Never
- Has child reached puberty  Yes  No

**PATIENT'S/PARENT'S ATTITUDE TOWARD TEETH, FACE, AND ORTHODONTIC TREATMENT—CHECK ALL THAT APPLY**

- Aware of any orthodontic problem.
- Any unusual dental experiences.
- Previous ortho consult or treatment.
- Any medical, dental or surgical problem not covered.

**WHY ARE YOU SEEKING THIS CONSULATION?**

- To correct overbite
- To eliminate crowding
- To close spaces
- To correct jaw dysfunction problem
- To eliminate face pain
- OTHER** \_\_\_\_\_
- To improve general appearance
- To improve facial proportions

**OTHER FAMILY MEMBERS WITH SIMILAR ORTHODONTIC CONDITIONS:**

- Father  Mother  Brother  Sister  Other \_\_\_\_\_

Brother's and Sister's (for children only):

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____

Use this area to describe THE THINGS THAT YOU WANT US TO CORRECT concerning your teeth, smile or facial appearance. Also include any questions which you would like us to answer.

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PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Unless 24 hour notice is given, there will be a charge for a broken appointment. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for any fee not covered under my insurance plan. I understand that credit report verification may be obtained in case financing of treatment is requested.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature (if minor—relationship to child)

