DR_____

WELCOME TO OUR OFFICE

TODAY'S DATE:_____

PATIENT'S NAME	❑ MALE ❑ FEMALE	BIRTHDATE
ADDRESS (ST)		CITY, STATE, ZIP
HOME PHONE	CELL PH #/CARRIER	PATIENT'S S.S.# (IF ADULT)
PLACE OF EMPLOYMENT (IF ADULT)	WORK PHONE	SCHOOL NAME
SPECIAL INTERESTS	WHAT (IF ANY) MUSICAL INSTRUMENT IS PLAYED?	

IF MINOR, COMPLETE THE FOLLOWING:

FATHER'S NAME		ADDRESS (ST.)
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
WORK PHONE		FATHER'S S.S.#
MOTHER'S NAME ❑ MRS. ❑ MS.		ADDRESS (ST.)
HOME PHONE	CELL PH #/CARRIER	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
WORK PHONE		MOTHER'S S.S.#

WHO WOULD BE RESPONSIBLE FOR THE ACCOUNT?		**ADDRESS (ST.)**
NAME OF INSURANCE CO. IF ORTHODONTIC COVERAGE IS AVAILABLE		
NAME OF INSURED	**INSURED D.O.B.**	**SOCIAL SECURITY NUMBER**
WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT CONFIRMATION BY: ❑ **PHONE** ❑ **EMAIL OR** ❑ **TEXT**		
HOME E-MAIL ADDRESS: **PRIMARY EMAIL** (PATIENT/MOTHER/FATHER): **SECONDARY EMAIL** (PATIENT/MOTHER/FATHER):		
SIGNATURE OF PATIENT OR PARENT		**DATE**

WHO RECOMMENDED OUR OFFICE TO YOU?
HAVE WE TREATED ANY OF YOUR RELATIVES? ❑ YES ❑ NO THEIR NAMES
PLEASE WRITE THE NAMES (AGES) OF OTHER CHILDREN IN YOUR FAMILY ( )
( ) ( ) ( )
WHO IS THE PATIENT'S DENTIST?
WHAT ARE THE DENTIST'S CONCERNS ABOUT YOUR TEETH?
HOW DO YOU FEEL ABOUT BRACES?
I'M INTERESTED IN ❑ BRACES ❑ INVISALIGN ❑ WHATEVER WORKS BEST

TMJ, JAW OR HEAD PAIN	YES	NO
DO YOU HAVE FREQUENT PAIN IN JAWS OR JAW JOINTS?		
DO YOU HAVE FREQUENT HEADACHES?		
HAS ANY DOCTOR EVER TOLD YOU THAT YOU MIGHT HAVE A TMJ PROBLEM?		
DO YOU HAVE A CLICKING, CRACKING, POPPING OR GRATING SOUND IN YOUR JAW JOINTS?		
ARE THE JAW (OR CHEWING) MUSCLES FREQUENTLY SORE?		
DO YOU FREQUENTLY EXPERIENCE RINGING IN THE EARS OR DIZZINESS?		
DO YOU FREQUENTLY EXPERIENCE TIGHTNESS, SPASMS OR PAIN IN THE MUSCLES OF SHOULDERS/BACK/NECK?		

PLEASE GIVE A BRIEF SUMMARY OF
(a) who has treated you (b) for how long (c) what was done & results

When answered by someone other than patient, "You" refers to patient.

MEDICAL HISTORY

DO YOU OR HAVE YOU EVER HAD:	YES	NO		YES	NO
HEPATITIS/LIVER PROBLEMS			BIRTH DEFECTS		
ALLERGY TO PENICILLIN			MEASLES		
ALLERGY TO LATEX			MUMPS		
ALLERTY TO NICKEL/METALS			CHICKEN POX		
DIABETES			SPEECH PROBLEMS		
EPILEPSY/SEIZURES			SWALLOWING PROBLEMS		
ASTHMA			FAINTING		
BREATHING PROBLEMS			EYE DISORDER		
HAY FEVER/ALLERGIES			GLASSES/CONTACTS		
SINUS PROBLEMS			GLAUCOMA		
HEART CONDITIONS/MURMUR			ULCERS/COLITIS		
BLEEDING PROBLEMS/ANEMIA			HIV/AIDS		
OSTEOPOROSIS			PHYSICAL HANDICAP		
ORAL OR IV BIOPHOSPHONATE TREATMENT			MENTAL HANDICAP		
			TUBERCULOSIS		
KIDNEY PROBLEMS			HIGH BLOOD PRESSURE		
REACTION TO DRUGS			RHEUMATIC FEVER		
REACTION TO ANESTHETIC			EATING DISORDER		
NERVE PROBLEMS			ADD/ADHD		
BACK OR NECK PROBLEMS			TONSILS/ADENOIDS REMOVED		
MAJOR SURGERY			TAKING MEDICATIONS NOW		

ANY COMMENTS ON ANY OF THE ABOVE OR ON OTHER HEALTH MATTERS YOU WOULD LIKE US TO KNOW

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? YES ❑ NO ❑

COMMENTS:

HAVE YOU HAD ANY PAST HOSPITALIZATIONS? YES ❑ NO ❑

COMMENTS:

DENTAL HISTORY

DO YOU OR HAVE YOU EVER HAD:	YES	NO
ANY PAST INJURY TO THE HEAD OR FACE?		
ANY PAST INJURY TO TEETH?		
ANY PREVIOUS ORTHODONTIC TREATMENT?		
SPEECH THERAPY, TONGUE THRUST THERAPY, OR MYOFUNCTIONAL THERAPY?		
ANY TOOTH SENSITIVITY?		
BLEEDING GUMS?		
AN UNFAVORABLE REACTION TO PAST MEDICAL OR DENTAL CARE?		
FREQUENT MOUTH ULCERS?		
ANY PREVIOUS EXTRACTIONS?		
RECENT DENTAL X-RAYS?		
HAS ANY NEAR RELATIVE EVER HAD FACIAL OR JAW SURGERY?		
HAS ANY NEAR RELATIVE EVER HAD A NOTICEABLE RECEEDING OR PROTUDING LOWER JAW?		
HAS ANYONE IN THE FAMILY HAD ORTHODONTIC TREATMENT?		
DO YOU SUCK YOUR FINGER OR THUMB? IF YES: ❑ NIGHT AND/OR ❑ DAY		
DO YOU EVER SUCK YOUR FINGER OR THUMB?		
DO YOU BITE OR SUCK ON THE INSIDE OF YOUR CHEEK?		
DO YOU BITE YOUR FINGERNAILS OR OTHER OBJECT?		
DO YOU GRIND YOUR TEETH? IF YES: ❑ NIGHT AND/OR ❑ DAY		
DO YOU CLENCH YOUR JAWS? IF YES: ❑ NIGHT AND/OR ❑ DAY		
IS YOUR DRINKING WATER AT HOME FLUORIDATED?		
DO YOU GET FLUORIDE TREATMENTS AT SCHOOL OR FROM YOUR DENTIST?		
HAVE YOU EVER HAD PERIODONTAL (GUMS) TREATMENT?		
HAVE YOU EVER HAD A ROOT CANAL?		
DO YOU FREQUENTLY CHEW CHEWING GUM?		
DO YOU ❑ SMOKE OR ❑ CHEW TOBACCO? IF YES, PLEASE INDICATE		
ARE YOU A MOUTH BREATHER?		
DO YOU SNORE?		