WELCOME TO OUR OFFICE

TODAY'S DATE_____

PATIENT'S NAME MALE / FEMALE		BIRTHDATE
ADDRESS (ST.)		CITY, STATE, ZIP
HOME PHONE	CELL PHONE	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 FOLLOWING:

FATHER'S NAME		ADDRESS (ST.)
HOME PHONE	CELL PHONE	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
BUSINESS PHONE		FATHER'S S.S.#
MOTHER'S NAME MRS. MS.		ADDRESS (ST.)
HOME PHONE	CELL PHONE	CITY, STATE, ZIP
OCCUPATION		WHERE EMPLOYED
BUSINESS 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: WORK E-MAIL ADDRESS (DAD / MOM); OTHER:		
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?

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" refer to patient

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD:

	YES	NO		YES	NO
HEPATITIS			BIRTH DEFECTS		
ALLERGY TO PENICILLIN			MEASLES		
ALLERGY TO LATEX			MUMPS		
ALLERGY TO NICKEL			CHICKEN POX		
DIABETES			SPEECH PROBLEMS		
EPILEPSY			SWALLOWING PROBLEMS		
SEIZURES			FAINTING		
ASTHMA			EYE DISORDER		
BREATHING PROBLEMS			GLASSES/CONTACTS		
HAY FEVER/ALLERGIES			GLAUCOMA		
SINUS PROBLEMS			ULCERS/COLITIS		
HEART CONDITION/MURMUR			HIV/AIDS		
BLEEDING PROBLEMS			PHYSICAL HANDICAP		
ANEMIA			MENTAL HANDICAP		
LIVER PROBLEMS			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 HAVE OR HAVE YOU 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?		
ANY UNFAVORABLE REACTION TO POST 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 PROTRUDING LOWER JAW?		
HAS ANYONE IN THE FAMILY HAD ORTHODONTIC TREATMENT?		
DO YOU SUCK YOUR FINGER OR THUMB? IF YES, CIRCLE NIGHT OR DAY		
DID YOU EVER SUCK YOUR THUMB OR FINGER?		
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, CIRCLE NIGHT AND/OR DAY		
DO YOU CLENCH YOUR JAWS?		
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 CIRCLE		
ARE YOU A MOUTH BREATHER?		
DO YOU SNORE?		