

# ORTHODONTIC PATIENT INFORMATION

Welcome to our office.

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated.

Thank you.

EMAIL \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SEX \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

PATIENT'S OCCUPATION OR SCHOOL LEVEL \_\_\_\_\_ PATIENT'S MARITAL STATUS: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT \_\_\_\_\_ HOME PHONE \_\_\_\_\_ SS# \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ EMPLOYER \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? Yes No

If YES by which company? \_\_\_\_\_

NAME OF PERSON TO BE CONTACTED IF PATIENT CANNOT BE REACHED

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY DENTIST \_\_\_\_\_ FAMILY PHYSICIAN \_\_\_\_\_ REFERRED BY \_\_\_\_\_

## FAMILY STATUS

SIBLINGS None \_\_\_\_\_ Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ LIVING Yes No

MOTHER'S NAME \_\_\_\_\_ LIVING Yes No

OTHER FAMILY MEMBERS WITH SIMILAR ORTHODONTIC CONDITION?

Father Brother Other  
Mother Sister Specify \_\_\_\_\_

PATIENT LIVING WITH: Mother Father Self Other: \_\_\_\_\_

## MEDICAL & DENTAL HISTORY:

PRESENT HEALTH: Good Fair Poor UNDER TREATMENT: Yes No

SPECIFY: \_\_\_\_\_

PRESENT DRUGS OR MEDICATION: Yes No

SPECIFY: \_\_\_\_\_

HAS PATIENT BEEN UNDER CARE OF A PHYSICIAN DURING THE PAST TWO YEARS OTHER THAN FOR ROUTINE EXAMINATION? Yes No

BIRTH DEFECTS Yes No

SPECIFY: \_\_\_\_\_

HAS PATIENT REACHED PUBERTY (MENSTRUATION, HAIR)? Yes No

PLEASE FILL OUT OTHER SIDE OF FORM

The following conditions are of interest to the orthodontist.

Has the patient ever had:

AIDS	Epilepsy	Hearing Disorder
Asthma	Endocrine Problems	Head or Face Injury
Anemia	Emotional Problems	Immune Disease
Blood Disease	Glaucoma	Kidney Trouble
Bone Disease	Hepatitis	Rheumatic Fever
Diabetes	Heart Disease	

COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient:

1. Have allergies to: Seasonal grasses \_\_\_\_\_ Food \_\_\_\_\_  
Drugs \_\_\_\_\_ Other \_\_\_\_\_
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually COMMENTS: \_\_\_\_\_
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose and throat specialist?

Yes No If YES: When \_\_\_\_\_ By Whom \_\_\_\_\_  
Tonsils removed \_\_\_\_\_ Adenoids removed \_\_\_\_\_

Does the patient have pain or clicking in jaw joint? Yes No.

Have any teeth been injured due to accidents or blows to the mouth? Yes No

Has the patient received or been requested to receive speech correction? Yes No

The following habits are of interest to the orthodontist. List information as it pertains to this patient:

Thumb sucking until age _____	Grinding of teeth	Yes	No
Finger sucking until age _____	Tongue thrusting		Yes No
Lip-biting or sucking Yes No	Other habits	Yes	No

Has the patient had any unusual dental experiences? Yes No

Specify: \_\_\_\_\_

Has the patient had previous orthodontic consultation or treatment? Yes No

Date: \_\_\_\_\_ Dr. \_\_\_\_\_

Are there any other medical, dental or surgical problems not covered above? Yes No

**PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:**

Dental checkups: Twice A Year Once A Year Only If Urgent Never

Date of last dental checkup \_\_\_\_\_ Were the patient's teeth cleaned? Yes No

Is the patient aware of any orthodontic problem? Yes No

Patient's interest in orthodontic treatment:

The Patient Wants Treatment	Treatment If Necessary	Unwilling But Agrees	Uncooperative		
Orthodontic consultation prompted by:	Patient	Dentist	Mother	Father	Spouse
Sibling	Physician	Friend	Other (specify): _____		

Why did the patient seek this consultation? \_\_\_\_\_

What is the primary problem? \_\_\_\_\_

What is expected from orthodontic treatment? \_\_\_\_\_

Additional comments you wish to make: \_\_\_\_\_

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM: \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_