

**\*\* Important: Please Complete History Form and Bring to First Appointment \*\***

Name \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Employed By \_\_\_\_\_ Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Special hobbies or interests \_\_\_\_\_

Other people you know in treatment \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

Dental Insurance  Yes  No      Orthodontic Insurance  Yes  No

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed By \_\_\_\_\_ Phone \_\_\_\_\_ Business Address \_\_\_\_\_

Social Security # \_\_\_\_\_

Person Financially Responsible \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_

**MEDICAL HISTORY.** (Circle yes or no and fill in blanks where required)

- 1. Are you in good health? ..... Yes No
- 2. Date of last dental exam \_\_\_\_\_ Is work completed? ..... Yes No
- 3. Have tonsils and/or adenoids been removed? At what age? \_\_\_\_\_ ..... Yes No
- 4. Are height and weight normal for age? ..... Yes No
- 5. Frequent colds, sore throat, or ear infections? ..... No Yes
- 6. Any major illness, AIDS, etc.? ..... No Yes  
If yes, list \_\_\_\_\_
- 7. Any allergies or drug sensitivity? ..... No Yes  
If yes, list \_\_\_\_\_
- 8. Taking medication now? ..... No Yes  
If yes, list \_\_\_\_\_
- 9. Under medical care now? ..... No Yes  
If yes, reason \_\_\_\_\_
- 10. Are you adopted? ..... No Yes
- 11. Circle any of the following for which you have been treated:
 

Diabetes	Asthma	Prolonged bleeding	Tonsillitis
Arthritis	Epilepsy	Nervous disorders	Brain injury
Heart trouble	Rheumatic fever	Endocrine problems	Tuberculosis

**DENTAL HISTORY:** (circle answer)

- 1. Have there been any injuries to the face, mouth, or teeth? ..... No Yes
- 2. Have you ever sucked your thumb or fingers? Until what age? \_\_\_\_\_ No Yes
- 3. Have you ever had habits, such as lip biting or tongue thrusting or finger nail biting? ..... No Yes
- 4. Do you have any speech problems? ..... No Yes
- 5. Have you ever had any speech therapy? ..... No Yes
- 6. Are you a mouth breather while asleep or awake? ..... No Yes
- 7. Are you aware of any missing or extra permanent teeth? ..... No Yes
- 8. Have you ever had orthodontic treatment? ..... No Yes
- 9. Name of orthodontist \_\_\_\_\_
- 10. What are you or your dentist most concerned about? \_\_\_\_\_

11. Signature \_\_\_\_\_ Date \_\_\_\_\_

**DENTAL INSURANCE INFORMATION:**

Employee Name \_\_\_\_\_ Employee Social Security # \_\_\_\_\_  
 Membership # \_\_\_\_\_ Employee Group # \_\_\_\_\_  
 Group Name \_\_\_\_\_  
 Name of Employer \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Name of Insurance Carrier \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_

BENEFITS OF ORTHODONTICS  
AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand the above paragraph. I also understand that my diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in the above medical or dental history.

\_\_\_\_\_  
Patient Date

CREDIT REFERENCES MAY BE CHECKED