

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

Name _____ Date _____

Social Security # _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____ Phone _____

Special hobbies or interests _____

Other children you know in treatment _____

Who can we thank for referring you to our office? _____

School _____ Grade _____

Dentist _____ Phone _____ Address _____

Physician _____ Phone _____ Address _____

Dental Insurance Yes No Orthodontic Insurance Yes No

Father's Name _____ Occupation _____

Employed By _____ Phone _____ Business Address _____

Mother's Name _____ Occupation _____

Employed By _____ Phone _____ Business Address _____

Are Parents Divorced _____ Separated _____ Widowed _____

Person Financially Responsible _____ Social Security # _____ Relationship _____

Phone _____ Address _____ Zip _____

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

1. Is the patient 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

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. Is patient adopted? No Yes

11. Circle any of the following for which the patient has 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. Has patient ever sucked their thumb or fingers? Until what age? _____ No Yes
- 3. Has patient ever had habits, such as lip biting or tongue thrusting or fingernail biting? No Yes
- 4. Does patient have any speech problems? No Yes
- 5. Has patient ever had any speech therapy? No Yes
- 6. Is patient a mouth breather while asleep or awake? No Yes
- 7. Are you aware of any missing or extra permanent teeth? No Yes
- 8. Has either parent or other children ever had orthodontic treatment? No Yes

9. What are you or your dentist most concerned about? _____

10. Person filling out this form(Please print) _____ Relationship _____

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/Parent

Date

CREDIT REFERENCES MAY BE CHECKED