

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 OR EMAIL | | |
| 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 <input type="checkbox"/> NO <input type="checkbox"/> 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 <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| COMMENTS: | | | | | |
| HAVE YOU HAD ANY PAST HOSPITALIZATIONS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 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 FLOURIDE 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? | | |