

Medical/Dental History

Date: _____

Patient's Name:	Sex:	Age:	Birthdate:
Prefers to be addressed by:	Referred by:		
Address:	City:	Zip:	Phone:
Father's Name:	Occupation:	Work Phone:	
Father's Employer:			
Mother's Name:	Occupation:	Work Phone:	
Mother's Employer:	Parent's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Siblings Name:	DOB:	Siblings Name:	DOB:
Siblings Name:	DOB:	Siblings Name:	DOB:
Guardian:	Home Phone:		
Guardian's Employer:	Occupation:	Work Phone:	
Person Responsible for Account: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other (State Name):			
Address:	Business Phone:	Home Phone:	

DENTAL INSURANCE

Primary Insurance Co:	Gr. #:	Ortho. Coverage: YES	NO
Insureds Name:	SS#:	Birthdate:	
Secondary Insurance Co:	Gr. #:	Ortho. Coverage: YES	NO
Insureds Name:	SS#:	Birthdate:	
Other Insurance Information:			

DENTAL HISTORY

Patient's Dentist:	Date of Last Visit:			
1. Have there been any injuries to the face, mouth or teeth?	YES	NO		
2. Has the patient had or presently have any of the following habits?	YES	NO	Thumb or finger sucking	Lip Biting Snoring
			Grinding of teeth at night	Mouth breathing
3. Has the patient been informed of any missing or extra permanent teeth?	YES	NO		
4. Is the patient aware of sores, lumps or irritated areas in the mouth?	YES	NO		
5. Has an orthodontist been consulted previously?	YES	NO		
	Name:	Date:		
6. Has the patient ever been treated for:	YES	NO	Bad Bite	TMJ Periodontal disease
	If so, by whom:			
7. Does the patient have any speech problems?	YES	NO		
8. Is the patient frightened or anxious about Orthodontic treatment?	YES	NO		
9. Is the patient concerned about the appearance of their teeth?	YES	NO		
10. Is there anything the patient would like to change about his/her smile?	YES	NO		
	If so, what:			
11. What aspect of dental treatment is the patient most concerned with?	Quality	Cost	Discomfort	Time
12. Reason for consultation:				
13. Has there ever been any orthodontic treatment for any other member of the family	YES	NO		
Are you satisfied with the results?	YES	NO		
Mother (Dr. _____) Father (Dr. _____) Brothers (Dr. _____) Sisters (Dr. _____)				

