A B C

# Patient Information

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Birthdate_____ Age _____ Social Security # _____Sex _____
Home # _____Cell # _____Email _____

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone_____

If patient is a minor, give parent's or guardian's name_____

Please list any siblings and their ages._____

Whom may we thank for referring you to our office?_____

# Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home #_____Cell #_____Work #_____

Previous Address (if less than 3 years)_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____Occupation_____ No. years employed _____

Social Security #_____ Birthdate_____ Work Phone _____

# Dental Insurance Information

Insured's Name_____Insured's Social Security # _____

Insurance Company_____Group No._____Member ID No._____

Insurance Co. Address_____Phone No._____

Do you have dual coverage? Yes____ No____ If yes:

Insured's Name_____Insured's Social Security # _____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address_____Phone No._____

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

## MEDICAL HISTORY

Physician_____ Date of Last Visit _____
Address_____Phone _____
Please circle Yes or No (If Yes, please fill in details)
Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have you ever been involved in a serious accident? _____
Circle any of the medical conditions below that you have had or currently have.

| | | | |
|---|---|---|---|
| Abnormal bleeding/Hemophilia | Diabetes | Herpes | Radiation/Chemotherapy |
| Anemia | Dizziness | High Blood Pressure | Rheumatic Fever |
| Arthritis | Epilepsy | HIV/Aids | Tuberculosis |
| Asthma or Hayfever | Gastrointestinal Disorders | Kidney problems | Tumor or Cancer |
| Bone Disorders | Heart Problems | Nervous Disorders | |
| Breast Cancer | Heart Murmur | Pneumonia | |
| Congenital Heart Defect | Hepatitis/Liver Problems | Prolonged Bleeding | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____
Are you taking any or have you taken any osteoporosis medications such as Zometa, Fosamax, etc. _____

## DENTAL HISTORY

Dentist_____ Date of Last Visit_____
What concerns you most about your teeth? _____
Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when you brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when ? _____
Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated ? _____
Yes No Has anyone in your family received orthodontic treatment ? _____
How did they feel about the result ? _____
What is your attitude toward receiving orthodontic treatment ? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning ? _____
Yes No Are you aware of your jaw clicking or popping ? _____
Yes No Are you aware of clenching your teeth during the day ? _____
Yes No Have you ever been told that you grind your teeth ? _____
Yes No Do you have "tension" headaches ? _____
Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school/work hours ? _____
Please list some hobbies or interests_____
Female patients only:
Yes No Are you pregnant? _____
Answer only if under age 17:
Yes No Has menstration started? If yes, at what age?_____

## BENEFITS

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 this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Drs. Cosse and/or Silmon to perform a complete orthodontic evaluation.

Signature:_____ Date:_____