**PATIENT INFORMATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name

 Last First Middle

Address

 Street City Zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #

If patient is a minor, give parent’s or guardian’s name

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 phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone

Cell/other phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address

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 # Birth date Work Phone

**DENTAL INSURANCE INFORMATION**

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Social Security #

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local 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.

**EMERGENCY INFORMATION**

Name of nearest relative not living with you

Complete address

 Street City Zip

Phone

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 operations?

Yes No Have you ever been involved in a serious accident?

Yes No Have seen a physician in the last 12 months? Why?

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia

Anemia Dizziness Herpes Prolonged Bleeding

Arthritis Epilepsy High Blood Pressure Radiation/Chemotherapy

Asthma or Hayfever Gastrointestinal Disorders HIV / Aids Rheumatic Fever

Bone Disorders Heart Problems Kidney problems Tuberculosis

Congenital Heart Defect Heart Murmur Nervous Disorders Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

# DENTAL HISTORY

General 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? Where?

Yes No Is any part of your mouth sensitive to pressure? Where?

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 What is your attitude toward receiving orthodontic treatment?

Yes No Has anyone in your family received orthodontic treatment? How did they feel about the result?

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 Have you ever experienced chronic ringing in your ears?

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?

Yes No Has menstruation started?

# 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 Dr. Jasun Mahaffey to perform a complete orthodontic evaluation.

Signature: Date: