



## Orthodontic Patient Information

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_

Street Address \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ Patient Cell Phone \_\_\_\_\_

Patient's E-Mail Address \_\_\_\_\_

Age \_\_\_\_ Birthdate \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex \_\_\_\_\_

Patient's Hobbies/Interests \_\_\_\_\_

Patient's School \_\_\_\_\_ School Grade \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Father's E-mail \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Email \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

\_\_\_\_\_

Referred by: \_\_\_\_\_

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## MEDICAL HISTORY

**Has the patient ever had any of the following? If yes, please explain below.**

<b>Adenoid Removal</b>	<b>Y N</b>	<b>Allergies</b>	<b>Y N</b>	<b>Anemia</b>	<b>Y N</b>
<b>Asthma</b>	<b>Y N</b>	<b>Birth Defects</b>	<b>Y N</b>	<b>Blood Disease</b>	<b>Y N</b>
<b>Bone Disease</b>	<b>Y N</b>	<b>Diabetes</b>	<b>Y N</b>	<b>Drug Allergies</b>	<b>Y N</b>
<b>Emotional Disorder</b>	<b>Y N</b>	<b>Head &amp; Face Injury</b>	<b>Y N</b>	<b>Hearing Disorder</b>	<b>Y N</b>
<b>Heart Disease</b>	<b>Y N</b>	<b>Hepatitis</b>	<b>Y N</b>	<b>Hormone Disorder</b>	<b>Y N</b>
<b>Immune Disease</b>	<b>Y N</b>	<b>Rheumatic Fever</b>	<b>Y N</b>	<b>Tonsils Removal</b>	<b>Y N</b>

**Does the patient require premedication for dental appointments? No Yes**

**Is the patient currently under the care of a physician? No Yes** \_\_\_\_\_

**Is the patient currently taking any drugs or medications? No Yes** \_\_\_\_\_

**Has the patient reached puberty? No Yes, since age** \_\_\_\_\_

**Is there any other medical problem not covered above? No If yes, please explain below.**

## DENTAL HISTORY

**Patient's Dentist** \_\_\_\_\_ **Date of Last Exam** \_\_\_\_\_

**Have any baby teeth ever been injured due to an accident? No Yes**

**Have any adult teeth ever been injured due to an accident? No Yes**

**Has the patient ever had a thumb or finger sucking habit? No Yes, until age \_\_\_ Yes, currently**

**Has the patient ever received speech correction? No Yes**

**Has the patient ever had any pain or clicking in the jaw joint? No Yes**

**Has the patient ever had any difficult or unusual dental experiences? No Yes**

**Is there any other dental problem not covered above? No If yes, please explain below.**

**Date** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Relation to Patient** \_\_\_\_\_