

PATIENT INFORMATION

Patient's Full Name _____ Prefers to be called _____
First, Middle, Last
Patient's Address _____ Home Phone (____) _____
Street City State Zip
Patient's Birth date ____/____/____ Age ____ Male Female Favorite Hobbies _____
Month Day Year
Patient's Dentist _____ School _____
Name City
Whom may we thank for referring you? _____ Other family members seen by us _____

RESPONSIBLE PARTY INFORMATION

Name _____ Married Single Divorced Relationship to patient _____
First, Middle, Last
Home Address _____ Home Phone (____) _____
Street City State Zip
Your Employer _____ Birth date _____ Social Security No. ____/____/____
Your Occupation _____ Work Phone (____) _____ No. of years employed _____
Spouse's Name _____ Spouse's address _____
First, Middle, Last Street City State Zip
Spouse's Employer _____ Birth date _____ Social Security No. ____/____/____
Spouse's Occupation _____ Work Phone (____) _____ No. of years employed _____
Primary Insurance and Subscriber _____ Secondary Insurance and Subscriber _____

HEALTH HISTORY

MEDICAL HISTORY

Please check if patient has, or has had...

- Joint Swelling or Arthritis
- Diabetes
- Bone Disorders
- Heart Trouble/Heart murmur
- Rheumatic Fever
- Hepatitis or Liver Problems
- Emotional Problems/ADDH
- Tuberculosis (TB)
- AIDS or HIV
- Epilepsy
- Prolonged Bleeding
- Endocrine Problems
- Tonsils Removed. If so, when? _____
- Asthma. If so, what medication(s)? _____
- Are you pregnant? How far along? _____

DENTAL HISTORY

Please check if patient has, or has had...

- Any injuries to face, mouth, teeth (Circle)
- Thumb, finger or lip sucking habit(s)
 Continuing Discontinued at age _____
- Mouth breathing when asleep, awake (Circle)
- Any known missing permanent teeth
- Any known extra permanent teeth
- Any teeth removed by extraction. If so, when? _____
- A tongue thrust problem
- Any clenching or grinding of teeth _ Day _ Night _ Both
- Any pain, popping or locking on opening or closing jaw
- Frequent headaches. If so, headaches/week ____ _AM _ PM
- Any muscle tenderness or stiffness in the jaw or neck. (Circle)
- Any ringing sounds in the ear or spells of dizziness. (Circle)
- Any previous treatment for TMJ or jaw joint problems
- Any previous orthodontic evaluation or treatment

List any **ALLERGIES** _____ Name of Physician _____

PLEASE LIST YOUR CHIEF CONCERN(S) AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH:

Signature of person completing form _____ Date _____ e-mail _____
Update health history and personal information Date _____ Date _____ Date _____ Date _____