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Practice Limited to Orthodontics
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Name_____ D.O.B_____ Sex_____

Address_____
City State Zip

Telephone #_____ Cell phone #_____

Email address_____Referred by _____

Dentist _____ Physician _____

Social Security #_____ Orthodontic dental insurance Yes___ No___

Name of dental insurance_____ Group/Policy #_____

Name of insured_____

Employed by_____ Occupation_____

Business address_____ Business telephone #_____

Spouse's name_____ Employed by_____

Business address_____ Business telephone #_____

Occupation_____

MEDICAL HISTORY

Are you in good health? Yes___ No___ Are you under the care of a physician for a major illness?

Yes____ No____ Explain: _____

_____

Do you have a latex allergy? Yes___ No___ List any other allergies:

_____

_____

Check any of the following for which you have been treated: Diabetes_____ Anemia_____ Endocrine problems_____

Pneumonia_____ Epilepsy_____ Prolonged bleeding_____Heart trouble_____ Asthma_____

Fainting/Dizziness_____ High blood pressure_____ Rheumatic fever_____Kidney involvement_____ Nervous

Disorder_____ Bone disorder_____ Liver involvement_____ Hepatitis_____ Osteoporosis_____

Other_____

(0ver)

List any medications being taken now: _____

_____

_____

Are you or do you suspect that you are pregnant: _____

Have you ever taken the following medication for Osteoporosis? Fosomax, Actonel, Boniva, Aredia, Zometa:

_____

DENTAL HISTORY

Have you had any injuries to your face, mouth or teeth? Yes___No___ Explain: _____

_____

Do you have any pain or clicking of your jaw joints? Yes___No___ Explain: _____

_____

Do you clench/grind your teeth? Yes____ No____ While asleep? Yes___ No___

Are you a mouth breather? Yes____ No____ While awake? Yes___ No___

Have you been informed of any missing or extra teeth? Yes___ No___

Do you have any crowns, bridges, or implants? Yes___ No___

Have you ever had any periodontal (gum) problems? Yes___ No___

Have any of your children had orthodontic treatment? Yes___ No___

What are your main concerns and your main reason for this examination/consultation?

_____

_____

_____

Signature of patient_____ Date_____