

PATIENT HISTORY FORM

EXAM / / Date / / Day / / Time / / Office / / 1 2 3

Patient's Name		Age	Sex M F	Adopted? YES NO	Birth Date / /
Address			City	Zip	Home Phone
Dentist - Name (last, first)/Phone No.		School/Employer	Grade/Position	Social Security No.	Height Weight
If Patient is a minor, give parent's or guardian's name		Brothers/Sisters		Whom may we thank for referring you to our office?	

Dental History

Chief Complaint		Date teeth were last cleaned?
Past dental facial trauma Yes <input type="checkbox"/> No <input type="checkbox"/>	Major accidents or surgery involving the face, neck, mouth or teeth?	Teeth broken, loosened or knocked out? Missing Teeth
Jaw Joint problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Locking Pain Noise	Discomfort opening or closing Frequent headaches Clenching or grinding
Oral problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Canker/cold sores Swollen/bleeding gums	Hepatitis Habits Thumb/finger Speech Mouth Breathing Day <input type="checkbox"/> Night <input type="checkbox"/>
Difficulty chewing or swallowing food? Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous orthodontic treatment/consultation Yes <input type="checkbox"/> No <input type="checkbox"/>	Orthodontist Outcome
Siblings had orthodontics? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name/Stage of treatment:	
Parents had orthodontics? Yes <input type="checkbox"/> No <input type="checkbox"/>	Mother Orthodontist Father	Results Does patient's stature, teeth or mouth resemble: M F Neither
Does anyone else in the family have a similar dentofacial condition: Crowded, retruded or protruded teeth, protruding lower jaw, receding chin		

Responsible Party Information

Name (last, first, middle)		Marital Status
Residence Street	City	State Zip
Mailing Address Street	City	State Zip
How Long at this address	Home Phone	Work Phone
Previous Address (if less than 3 yrs.) Street	City	State Zip
Social Security No.	Birth Date	Relationship to Patient
Employer	Occupation	No. of Years Employed
Spouse's Name (last, first, middle)	Relationship to Patient	No. of Years Employed
Employer	Occupation	No. of Years Employed
Social Security No.	Birth Date	Work Phone

Orthodontic Insurance Info.

Insured's Name		Insured's Social Security No.
Insurance Company	Group Number	Phone Number
Insurance Company Address Street	City	State Zip
Do you have dual coverage? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes:	Insured's Name	Insured's Social Security No.
Insurance Company	Group Number	Phone Number
Insurance Company Address Street	City	State Zip
Insured's Employer	Occupation	No. of Years Employed

Emergency Information

Name of nearest relative not living with you		Relationship to Patient
Complete Address Street	City	State Zip
Phone		

General Information

Who first noticed the problem? Pt <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	
Is the patient self-conscious of his/her teeth? Very <input type="checkbox"/> Moderate <input type="checkbox"/> Unconcerned <input type="checkbox"/>	Instruments
Attitude toward wearing braces: Eager <input type="checkbox"/> Resigned <input type="checkbox"/> Indifferent <input type="checkbox"/> Opposed <input type="checkbox"/>	Sports
Does the patient brush his teeth: In the morning <input type="checkbox"/> After lunch <input type="checkbox"/> After dinner <input type="checkbox"/> Before bed <input type="checkbox"/>	Interests
Do you have any questions about orthodontic treatment?	
What special attention would be effective in working with the patient?	
Are you aware that the success of orthodontic treatment is heavily dependent upon the degree of cooperation received? Yes <input type="checkbox"/> No <input type="checkbox"/>	

I certify the above information is correct. Signature (parent's signature if minor) _____

I understand that where appropriate, credit bureau reports may be obtained.

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)