Welcome to Our Practice		**Today's Date**		
Patient Name		Birth Date		Age
Address	City		State	Zip
Primary Phone #		School		Grade
SS#		DL#		
Siblings in treatment?	If yes, please list:			
Does patient play Sports or Instruments?	If yes, list:			
Dentist	Phone #	Physician	Phone #	

Information below applies to underage patients: To be completed by parent or guardian.

Mother's Name			**Father's Name**		
Home #	Cell #		Home #	Cell #	
Is address same as patients? Yes No If not please list Address information below:			Is address same as patients? Yes No If not please list Address information below:		
Address			Address		
City	State	Zip	City	State	Zip
List spouse information if different than father's info:			List spouse information if different than father's info:		
Name	Phone #		Name	Phone #	
Employer	Work #		Employer	Work #	
Responsible Party Email:			Responsible Party Email:		

Legal Guardian/Temporary Care Taker Name:			
Relationship to Patient		Phone #	
Address	City	State	Zip
Information regarding custody situation:			

Dental Insurance: Orthodontic Coverage? **Yes No**			**Dental Insurance: Orthodontic Coverage?** **Yes No**		
Ins Name			Ins Name		
Subscriber Name			Subscriber Name		
Subscriber SS#	DOB		Subscriber SS#	DOB	
Claims Address			Claims Address		
City	State	Zip	City	State	Zip
Relationship to Patient			Relationship to Patient		
Employer			Employer		

Is patient currently taking medications? If yes, please list:	Yes	No
Any Allergies? If yes, please list:	Yes	No

Patient Name:____

Dental History: Date of last dental cleaning: Is work complete?	Yes	No
Have there ever been any injuries to face, mouth, or teeth?	Yes	No
Has patient ever sucked their thumb or fingers? Until what age?	Yes	No
Has patient ever had any speech therapy?	Yes	No
Is patient a mouth breather while asleep or awake?	Yes	No
Has either parent or other children ever had orthodontic treatment?	Yes	No
Do you or your dentist have special concerns? Please list.	Yes	No

Medical History Is patient adopted?	Yes	No
Is patient in good health?	Yes	No
Have tonsils and/or adenoids been removed? If yes, at what age?	Yes	No
Are height and weight normal for age?	Yes	No
Frequent colds, sore throat or ear infections?	Yes	No
Any major illness? If yes, please describe:	Yes	No
Is patient currently under medical care?	Yes	No
Has patient been treated for any of the following? If yes, please circle: Diabetes Asthma Prolonged Bleeding Tonsillitis Heart Trouble Rheumatic Fever Arthritis Tuberculosis Epilepsy Nervous Disorder Brain Injury Endocrine Problems	Yes	No

Section for Female Patients Only		
Has menstrual cycle begun?	Yes	No
Are you taking birth control?	Yes	No
IMPORTANT: ARE YOU PREGNANT AT THIS TIME? IF YES, HOW MANY WEEKS?	Yes	No
Are you nursing?	Yes	No

BENEFITS OF ORTHODONTICS AESTHETICS, HEALTH AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth and general function of the teeth and 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 the above paragraph. I also understand that my diagnostic records may be used for educational purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in the above medical or dental history.

____

Parent/Guardian Date

OFFICE USE ONLY	**MEDICAL HISTORY UPDATE**	**CLINICAL USE ONLY**
I verbally reviewed the medical and dental information above with the parent/guardian and patient named herein. Initial:________________ Date:________________ Doctor's Comments: ____________________	Date:__________ Signature:____________ Comments:____________ ____________________ Date:__________ Signature:____________ Comments:____________ ____________________	DATE________________ CEPH________________ PANO________________ PHOTO_______________ WAX BITE_____________ IMP_________________ **MEDICAL ALERT:** ____________________ ____________________