

Please fill out this form and bring it with you to your first appointment. We look forward to meeting you.

Part I – Patient Information

Last Name: _____ First Name: _____ MI: _____
Nickname: _____ Sex: Male () Female ()
Address: _____
City, State & Zip: _____
Years at current address: _____ Home Phone: _____
Email Address: _____ Would you like to receive notices by e-mail: Y / N
Date of Birth: _____ Age: _____ SS# _____
Employer: _____ Employer Address: _____
Work Phone Number: _____ Occupation: _____ Years Employed: _____
Dental Insurance Carrier: _____ Subscriber Number: _____

Part II – Spouse or Closest Relative:

Last Name: _____ First Name: _____ MI: _____
Address: _____
City, State & Zip: _____
Years at current address: _____ Home Phone: _____
Date of Birth: _____ Age: _____ SS# _____
Employer: _____ Employer Address: _____
Work Phone Number: _____ Occupation: _____ Years Employed: _____
Dental Insurance Carrier: _____ Subscriber Number: _____

Who is Financially Responsible: _____
Whom may we thank for this referral: _____
Emergency contact person: _____ Phone Number: _____

Part III – Patient Dental History:

Dentist: _____ Phone: _____
Address: _____ Last Exam: _____

What is your chief complaint: _____
Does anyone else in the family have any similar conditions? (crowded, protruded teeth or jaws, poor bite): _____
Any family member received orthodontic treatment? _____ Who? _____
Tonsils and adenoids present? _____ Any tooth clenching or grinding at night? _____
Any thumb or finger habits? _____ To what age? _____
Other habits? _____ Smoking/ tobacco habits? _____ Difficulty chewing food? _____

Any difficulty in breathing through the nose, awake or asleep? _____
 Any clicking or pain in jaw? _____ Teeth sensitivity to cold, heat, sweets or pressure? _____
 Do you feel you brush and clean your teeth properly? _____ Floss teeth? _____
 Are you in good health? _____ Patients weight: _____ Height: _____
 Are you currently under a physicians care? _____ If yes, please describe: _____
 Are you taking any medications? _____ If yes, please list: _____

Part IV - Medical History:

Physician: _____ Phone: _____
 Address: _____ Last Exam: _____

For the following questions circle yes, no, or don't know/ understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

| | | | |
|-------------|-----------------------------------|-------------|--|
| yes no dk/u | Allergies to Drugs | yes no dk/u | Sinus Problems |
| yes no dk/u | Allergies to Anesthetics | yes no dk/u | Rheumatic Fever |
| yes no dk/u | Hay Fever or Allergies in general | yes no dk/u | Neurological Problems |
| yes no dk/u | Any Heart Ailments | yes no dk/u | Thyroid Disorders |
| yes no dk/u | Heart Murmur | yes no dk/u | Eye Disorders |
| yes no dk/u | High Blood Pressure | yes no dk/u | Tonsillitis |
| yes no dk/u | Anemia or Blood Problems | yes no dk/u | Tuberculosis |
| yes no dk/u | Arthritis | yes no dk/u | Ulcer or Colitis |
| yes no dk/u | Radiation Treatments | yes no dk/u | Venereal Disease |
| yes no dk/u | Diabetes | yes no dk/u | Headaches |
| yes no dk/u | Asthma | yes no dk/u | Jaw "Locking" |
| yes no dk/u | Stroke | yes no dk/u | Ear-aches, ringing, ear-stuffiness |
| yes no dk/u | Kidney Problems | yes no dk/u | Psychiatric/ Emotional Problems |
| yes no dk/u | HIV Positive or AIDS Virus | yes no dk/u | Excessive Bleeding from cut/extraction |
| yes no dk/u | Respiratory Disease | yes no dk/u | History of Fainting |
| yes no dk/u | Liver Problems or Hepatitis | yes no dk/u | Pregnancy, If so what month _____ |
| yes no dk/u | Malignancies | yes no dk/u | Stomach or Intestinal Disease |
| yes no dk/u | Tumors or Growths | yes no dk/u | Any Surgeries, If so what _____ |

Part V – Patient Consent:

Dr. New has my permission to obtain diagnostic materials she deems necessary for orthodontic evaluation. I also authorize her to provide other health care providers with information regarding my orthodontic care if considered appropriate. I also understand it is my responsibility to keep Dr. New's office informed of any change in medical or dental health status and that when appropriate, a credit bureau report may be obtained.

Patient's Signature: _____ Date: _____