Confidential Patient Information			
First Name:	Middle Name:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	State:	Zip:
Main Phone:	2nd/Cell Phone:	Email:	Social Security #:
If patient is a minor, give parent's or guardian's name:		If patient is a minor, who does the patient live with?	
Please list the names of family currently in the practice:			
Whom may we thank for referring you to our practice?			

Financial Party Information			
First Name:	Middle Name:	Last Name:	
Marital Status:	Relationship to Patient:	Birthdate:	
Address:	City:	State:	Zip:
Email:	Main Phone:	2nd/Cell Phone:	Work Phone #:
Social Security #:	Employer:	Occupation:	Length of Employment:
Spouse/Other Parent's First Name:	Middle Name:	Last Name:	
Relationship to Patient:	Social Security #:	Birthdate:	
Employer:	Occupation:	Length of Employment:	Work Phone #:

Dental Insurance Information	
If Policy Holder is not the Responsible Party, please list Address and Date of Birth.	
Policy Holder's Address:	Policy Holder's D.O.B.:

Policy Holder's Name:	Relationship to Patient:	Policy Holder Employer:	
Insurance Company:	Subscriber ID # (if not available give SSN):	Group No.:	
Insurance Co. Address:	City:	State:	Zip:
Insurance Company Phone No.:			
Do you have dual dental coverage? (If yes, complete information below)			
Policy Holder's Name:	Relationship to Patient:	Policy Holder Employer:	
Insurance Company:	Subscriber ID # (if not available give SSN):	Group No.:	
Insurance Co. Address:	City:	State:	Zip:
Insurance Company Phone No.:			

Emergency Information	
Name of nearest relative not living with you:	Complete Address:
Phone:	Relationship to Patient:

Dental History	
Dentist Name:	Last Dental Visit:
Has the patient had an orthodontic consult or treatment? If so, when?	
Does the Patient need to premedicate prior to dental visit?	
What is the patient's main orthodontic concern?	
Please mark YES if the patient has had any of the conditions listed below, either now or in the past. Cannot be blank.	
Speech problems/therapy?	Clench or grind teeth?
Oral habits (thumb/finger sucking, lip/nail biting)?	Injury to face, jaw, teeth or mouth?
Discomfort from teeth or gums?	Pain, tenderness or noise in either jaw?
Frequent headaches?	Chipped or injured permanent teeth?
Previous periodontal (gum) treatment?	Mouth breathing?

Snores during sleep?	Any missing or extra permanent teeth?
Thumb or finger habit as a child?	Jaw fractures, cysts, mouth infections?
Problems with food trapped between teeth?	Is all dental work completed at this time?
If any of the above dental questions were answered 'Yes', please explain:	
Do you have a history of jaw joint problems?	Have you been treated for "TMJ"?
Do you notice clicking or popping in your jaw joint?	Do you clench your teeth?
Has your jaw ever locked?	Do you have difficulty chewing or opening your mouth?
Does your bite feel uncomfortable or unusual?	
Do you experience soreness in the muscles of your face or around your ears?	
If any of the above TMJ questions were answered 'Yes', please explain:	

Medical History		
Physician Name:	Date of Last Physical:	
Is the patient now under the care of a physician (other than routine)? If so, what is being treated?		
List any medications currently taken by the patient (include non-prescription):		
Allergies or drug reactions to:		
Latex	Penicillin or other antibiotics	Aspirin, Ibuprofen, Tylenol
Local anesthetics	Metal Allergy	Milk Allergy
Other:		
List any drug allergies or sensitivities (not listed above) that the patient may have:		
Please mark YES if the patient has had any of the conditions listed below, either now or in the past. Cannot be blank.		
Heart Murmur	Damaged or Artificial Heart Valves	Congenital Heart Defect
Heart Disease	Rheumatic Fever	Angina
Heart Attack/Stroke	Hemophilia	Anemia/Blood Disorder

HIV/AIDS	Tonsils/Adenoids Removed	Arthritis/Joint Problems
Large Tonsils	Bone Fractures/Trauma to Face/Jaw	Prosthetic Joints
Diabetes	Growth Problems	Cancer
Received Radiation Treatment	Bone Disorders/Bone Loss	Seizures/Epilepsy/Neurological Disease
FEMALES: Are you pregnant?	Take Bisphosphonates (Fosamax/Boniva	
If any of the above medical questions were answered 'Yes', please explain:		

Patient Motivation for Orthodontic Treatment
Teeth - If your teeth could be changed, how would you like them to change?
Face – If your facial appearance could be changed, what would you change?
Symptoms – If you want to reduce pain or discomfort, please be specific about its location.

Patient Under 18			
Height:	Weight:	School:	Grade:
Has patient begun puberty:		If patient is a girl, has menstruation begun:	
If patient is a boy, has their voice changed or have facial hair:			
Has the patient grown in the past year or has their shoe size changed recently:			
Has either biological parent ever had orthodontic treatment:			

I have received a Notice of Privacy Practices.
Signature (Parent's signature if minor):

Update (date & initial) Update (date & initial) Update (date & initial) Update (date & initial)

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.