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Orthodontic Patient Information and Health History Form

Patient Information

Patient Name _____
LAST FIRST M.I.
 Nickname _____
 Date of Birth _____ Age _____
 Home Address _____
 City _____ State _____ Zip _____
 Social Security# _____ Sex _____
 Cell Phone _____
 E-mail Address _____

Adult Patients

Martial Status Single Married Widowed Separated
 Employer _____
 Work Phone _____ Occupation _____

Patients Under 18

Lives with Mother Father Both Other _____
 School _____ Year of HS Grad _____
 Interests and Hobbies _____

Account Information

Person Responsible for the Account

Name _____
LAST FIRST M.I.
 Relation to Patient _____
 Billing Address _____
 City _____ State _____ Zip _____
 Social Security# _____ D.O.B. _____
 Cell Phone _____ Work Phone _____

Additional Information

Has the pt had a previous ortho consultation? Yes No
 Has the pt had previous orthodontic treatment? Yes No
 Is the patient comfortable going to the dentist? Yes No
 How many times per day does pt. brush? _____
 Chief orthodontic concern? _____

Dental Insurance Information

Primary Insurance

Insurance Company _____
 Subscriber Name _____
 Subscriber D.O.B. _____
 Subscriber Employer _____
 Group# _____ Subscriber ID# _____
 Patient's Relationship to Subscriber Self Spouse Child

Secondary Insurance

Insurance Company _____
 Subscriber Name _____
 Subscriber D.O.B. _____
 Subscriber Employer _____
 Group# _____ Subscriber ID# _____
 Patient's Relationship to Subscriber Self Spouse Child

Dentist and Physician Information

Former or Current Dentist _____
 Address/Clinic Location _____
 City _____ State _____ Zip _____
 Phone _____ Last visit _____

Family Physician _____
 Address/Clinic Location _____
 City _____ State _____ Zip _____
 Phone _____ Last visit _____

Does the patient have?

Difficulty in opening, chewing or swallowing? Yes No
 Pain or clicking in jaw joint? Yes No
 Pain on chewing, yawning or wide opening? Yes No
 Pain in or about the ears or cheeks? Yes No
 A jaw that 'locks', 'gets stuck' or feels unusual? Yes No
 Noises in or from the jaw joints? Yes No

Dental History

Has the patient ever had:

- | | | |
|--------------------------|--------------------------|--|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury to head or neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Injury to face, jaw, teeth, or gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Discomfort from teeth or gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Teeth sensitive to hot or cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoid chewing on one side |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Gum treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Fluoride treatment |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Grind or clench teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain, tenderness, noise in either jaw |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck / shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Splint therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral habits (thumb / finger / lip / nails) |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal swallowing (tongue thrust) |
| <input type="checkbox"/> | <input type="checkbox"/> | Speech problems / therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent sore throats |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent gum chewing |

If yes to any of the above, please give details: _____

Medical History

Has the patient ever had:

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | ADD / ADHD |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Breathing Difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism / Asperger's / PPD - NOS |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth / Congenital Defects |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to latex, metal, drug, food, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Seizure |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches / Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Oral Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis / Osteopenia |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |

Thank you for coming in!

Which of these best describes how you found Pulver Ortho?

- Referred by a friend or family member
- _____
- Please let us know who so we may send them a thank you card.
- Referred by my insurance provider / website
- Drove by your office / close to me
- Google / online search
- Referred by your dentist _____
- Community event _____
- Other _____

Medications

Medication	Reason

Are there any medications that have been prescribed but not taken? Yes No

Does the pt need to pre-medicate / take an antibiotic prior to dental procedures? Yes No

Have the pt ever taken Bisphosphonates? Yes No

Authorization

I authorize release of any information regarding my or my child's orthodontic treatment to my dental and/or medical insurance company. I have read the above questions and understand them. To my knowledge, the above information is correct. If there are any changes in this medical history, I will inform the Laird Orthodontics.

Print Name

Orthodontist Signature

Patient / Guardian Signature

Date