Date

Patient’s Name

\_\_\_\_

Last First Middle

Address

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_

\_\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_\_

\_\_\_\_

Street City Zip

Cell Phone

\_\_\_

\_\_

Home Phone Work Phone

Birthdate

E-mail Address

Full Name of Parent or Legal Guardian Whom may we thank for referring you to our office?

# RESPONSIBLE PARTY INFORMATION

Name

Last First Middle

Residence

Street City Zip

Mailing Address

Street City Zip

\_\_

\_\_\_

\_\_\_

\_\_\_\_\_

Home Phone

Work Phone

Relationship to Patient

Social Security #

Birthdate

Employer Employer’s Address

Street City Zip

# DENTAL INSURANCE INFORMATION

Insured’s Name

Insured’s ID #

Insurance Company

Group No.

Insurance Company Address

Do you have dual coverage? Yes No

If yes:

Insured’s Name

Insured’s Social Security #

Insurance Company

Group No.

# EMERGENCY INFORMATION

Name of nearest relative not living with you Residence

Street City Zip

Phone

Signature (Parent’s signature if minor)

Page 1 of 3

# DENTAL HISTORY

Dentist

Date of Last Visit

What concerns you most about your teeth? Yes No Are you presently in any dental pain? Yes No Have you ever experienced any unfavorable reaction to dentistry? Yes No Have you ever lost or chipped any teeth? Yes No Have there been any injuries to face, mouth or teeth? Yes No Is any part of your mouth sensitive to temperature or pressure? Yes No Do your gums bleed when you brush? Yes No Do you have any type of thumb or tongue habit? Yes No Are you a mouth breather? Yes No Have you ever seen an orthodontist? If yes, who and when? Yes No What is your attitude toward receiving orthodontic treatment? Yes No Has anyone in your family received orthodontic treatment?

How did they feel about the result?

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping? Yes No Are you aware of clenching your teeth during the night? Yes No Have you ever been told that you grind your teeth? Yes No Do you have “tension” headaches? Yes No Have you ever experienced chronic ringing in your ears? Yes No If the patient is under age 16, height of parents? Mom Dad Yes No Are you aware that some appointments will be during school/work hours? Please list some hobbies or interests

# MEDICAL HISTORY

Physician

Date of Last Visit

Address Phone

\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_\_\_

\_\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_\_\_

\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_\_\_\_

\_\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

Please circle Yes or No (If yes, please fill in details)

|  |  |  |
| --- | --- | --- |
| Yes | No | Are you taking any medication?  |
| Yes | No | Are you allergic to any medication?  |
| Yes | No | Do you have a history of a major illness?  |

|  |  |  |
| --- | --- | --- |
| Yes | No | Have you had any major operations?  |
| Yes | No | Have you ever been involved in a serious accident?  |

Circle any of the medical conditions below that you have had or currently have:

\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | GI Disorders | HIV/AIDS | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of?

Female Patients only:

|  |  |  |
| --- | --- | --- |
| Yes | No | Are you pregnant?  |
| Yes | No | Has menstruation started?  |

# BENEFITS

Benefits of Orthodontics:Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general 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 this paragraph. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Ferry to perform a complete orthodontic evaluation.

Signature

Date