PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take.

Medication _____ Taken for ___ Medication ____ Taken for_____ _____

Medication _____ Taken for _____ Medication _____ Taken for _____

Have you ever taken any medications to strengthen your bones? Please describe. _____

Have you noticed any changes in your face or jaws? _____

Are you pregnant? __ Yes __ No Are you trying to become pregnant?__ Yes __ No

MEDICAL HISTORY

Now or in the past, have you had:

Y /N Hereditary or developmental conditions?
Y /N Bone fractures, or major injuries?
Y /N Any injuries to face, head, neck?
Y /N Arthritis or joint problems?
Y /N Diabetes or low sugar?
Y /N Kidney problems?
Y /N Cancer, tumor, radiation treatment or chemotherapy?
Y /N Stomach ulcer, hyperacidity, acid reflux?
Y /N AIDS or HIV positive?
Y /N Hepatitis, jaundice or other liver problem?
Y /N Mononucleosis, tuberculosis, pneumonia?
Y /N Seizures, fainting spells, neurologic problem?
Y /N Vision, hearing, or speech problems?
Y /N High or low blood pressure?
Y /N Excessive bleeding or bruising, anemia?
Y /N Heart defects, heart murmur, rheumatic heart disease?
Y /N Frequent headaches or migraines?
Y /N Asthma, sinus problems, hay fever? Tonsil or adenoid condition?
Y /N Do you frequently breathe through your mouth?

ıve you had allergies or reactions to any of the following:

Y /N Latex (gloves, ballons)
Y /N Metals (jewelry, buttons)
Y /N Acrylics
Y /N Aspirin
Y /N Ibuprofen (Motrin, Advil)
Y /N Penicillin
Y /N Other antibiotics

DENTAL HISTORY

Y /N Chipped or injured baby or permanent teeth?
Y /N Any sensitive or sore teeth?
Y /N Bleeding gums, bad taste or mouth odor?
Y /N History of speech problems or speech therapy?
Y /N Difficulty breathing through nose?
Y /N Mouth breathing habit or snoring at night?
Y /N Frequent oral habits (sucking finger, chewing pen, etc)?
Y /N Tooth grinding or clenching?
Y /N Clicking, locking in jaw joints?
Y /N Soreness in jaw muscles or face muscles?
Y /N Ringing in ears, difficulty in chewing or opening jaw?
Y /N Have you ever had an orthodontic consultation or treatment before now?

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company. Signature _____

Date_____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____

Date_____

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Patient Adult Information

PATIENT

Date _____ Patient's First and Last name _____ Middle initial _____

Title__ Mr. __ Mrs. __ Miss __ Dr.__ Other I prefer to be called _____

Birth date _____ What sex were you assigned on your birth certificate? __ Male __ Female

What is your current gender identification? __ Male __ Female __ Other What are your preferred pronouns? _____

Marital Status __ Single __ Married __ Separated __ Divorced __ Widowed

Home address _____ City, State, Zip code_____

Cell phone _____ Home phone _____ Work phone _____

E-mail address(es) _____

Occupation _____ Employer_____

Emergency Contact

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title __ Mr. __ Mrs. __ Miss __ Dr.

Address (if different than patient address) _____

Cell phone _____ Home phone _____ Work phone _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ Yes __ No __ Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ Yes __ No __ Don't know