* Ortho (Adult/ Child)

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* General Dentistry
* Pediatric Dentistry
* Oral Surgery

Date

# *Patient Information*

Patient Name Age Birthdate

Street Address Male Female \_

City State Zip \_ Home Phone Email \_ Whom may we thank for referring you? School Grade \_ Family Dentist Last Visit \_

# *Patient Health History*

Are you under the care of a doctor at the present time? If YES explain

Date and reason for your most recent visit to a physician ­

Please check any of the following:

* Are you allergic to any food, metal, medicine, or latex? If so, what?
* Are you taking any pills or drugs at the present time? If so, what? \_
* Do you have to premedicate for a dental treatment?--------------------------------
* Have you ever had any kind of orthodontic treatment? If so, when? \_
* Did you ever suck your thumb or fingers? If so, until what age? \_
* Have you had your tonsils or adenoids removed? If yes, when? \_
* Do you, or did you, have any other oral habits (nail biting, lip biting, cuticle picking, etc.)? \_
* Have you ever taken bisphosphonates to treat bone, blood or endocrine disorders? Please check any of the following if you have ever been told that you have the condition or received treatment:
* heart condition

(Heart murmur, heart attack, mitral valve prolapse, etc.)

* blood pressure is too high or too low
* rheumatic heart disease or rheumatic fever
* diabetes or hypoglycemia
* hepatitis or any liver disease
* bone disease, or bone fracture
* disease of the eyes
* psychiatric care
* prolonged bleeding
* sleep apnea or snoring

D TMJ problems

* asthma or allergies
* blood disease

D stroke

D epilepsy

* tumor or cancer
* AIDS or HIV positive infection
* accidents to your head, face or teeth
* venereal disease
* periodontal disease
* Y □N Bad breath
* Y □N Bleeding gums
* Y □N Food collection between teeth
* Y □N Grinding or clenching teeth
* Y □ N Loose teeth or broken fillings
* Y □ N Periodontal treatment
* Y □N Sensitivity to hot/cold
* Y □N Teeth sensitivity
* Y □N Sores or growths in mouth
* Y □ N Have you had any surgeries?
* Y □N Have you ever had any complications with general anesthesia or sedation?

Have you had any serious illnesses other than those above? If so, explain.

- ..,.

***Responsible Party Information***

## Responsible Party Name: Relationship to Patient:

EmaiI Address SS# \_

Street Address Birthday \_

City State Zip \_ How long at this address? Home Phone

Previous address (if less than 3 years) EmpIoyer Occupation------------ # of years employed Marital Status

Work Phone Cell Phone

Dental Insurance Company Group # Dental Insurance ID# is this the primary policy? \_

## Responsible Party Name: Date:

EmaiI Address SS#----------

Street Address Birthday ---------

City State Zip ----------

How long at this address? Home Phone Previous address (if less than 3 years)

EmpIoyer Occupation

# of years employed Marital Status Work Phone Cell Phone

Dental Insurance Company Group#

DentaI Insurance ID # is this the primary policy? ----

We are also attempting to establish the demographic makeup of our orthodontic families. Could you please also provide family members living at the same address:

Name Age Birthday

***Patient Information I Health History Update (Office Use Only)***

Responsible Party Signature Date

Responsible Party Signature Date

Responsible Party Signature Date

Responsible Party Signature Date

Responsible Party Signature Date