westside
Orthodontics & Family Dentistry

- ❑ Ortho (Adult / Child)
- ❑ General Dentistry
- ❑ Pediatric Dentistry
- ❑ Oral Surgery

Patient Information

Date_____

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
- ❑ TMJ problems
- ❑ asthma or allergies
- ❑ blood disease
- ❑ stroke
- ❑ 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. _____

_____

_____

_____

American Association of Orthodontists

Responsible Party Information

Responsible Party Name: _____ **Relationship to Patient:** _____

Email Address _____ SS# _____

Street Address _____ Birthday _____

City _____ State _____ Zip _____

How long at this address? _____ Home Phone _____

Previous address (if less than 3 years) _____

Employer _____ 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:** _____

Email Address _____ SS# _____

Street Address _____ Birthday _____

City _____ State _____ Zip _____

How long at this address? _____ Home Phone _____

Previous address (if less than 3 years) _____

Employer _____ Occupation _____

# of years employed _____ Marital Status _____

Work Phone _____ Cell Phone _____

Dental Insurance Company _____ Group # _____

Dental 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 / 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 _____