ORTHODONTIC PATIENT INFORMATION

Welcome to our office.

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order to thoroughly diagnose any condition it is necessary to have accurate background and health information. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated.

Thank you.

PATIENT'S NAME _____ AGE _____ BIRTHDATE _____ SEX _____

HOME ADDRESS _____ HOME PHONE _____
STREET CITY ZIP CODE

PATIENT'S OCCUPATION OR SCHOOL LEVEL _____ BUSINESS PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT _____ HOME PHONE _____

RELATIONSHIP _____ OCCUPATION _____ EMPLOYER _____

IS PATIENT COVERED BY INSURANCE FOR ORTHODONTIC TREATMENT? Yes No

If YES, by which company? _____

NAME OF PERSON TO BE CONTACTED IF PATIENT CANNOT BE REACHED

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

FAMILY DENTIST _____ FAMILY PHYSICIAN _____ REFERRED BY _____

FAMILY STATUS

FATHER'S NAME _____

MOTHER'S NAME _____

OTHER FAMILY MEMBERS HAVING ORTHODONTIC TREATMENT

Specify _____

_____

PATIENT LIVING WITH: (circle one) Mother Father Self Other: _____

MEDICAL & DENTAL HISTORY:

PRESENT HEALTH: Good Fair Poor UNDER TREATMENT: Yes No

SPECIFY: _____

PRESENT DRUGS OR MEDICATION:

SPECIFY: _____

HAS PATIENT BEEN UNDER CARE OF A PHYSICIAN DURING THE PAST TWO YEARS OTHER THAN FOR ROUTINE EXAMINATION?

SPECIFY: _____

BIRTH DEFECTS

SPECIFY: _____

HAS PATIENT REACHED PUBERTY (MENSTRUATION, HAIR)?

PLEASE NOTIFY US IF YOU ARE NOW PREGNANT OR BECOME PREGNANT DURING TREATMENT

(OVER PLEASE)