

## Patient Information

Date \_\_\_\_\_

 Patient's Name \_\_\_\_\_ / \_\_\_\_\_ Male  Female   
Last First Middle Nickname

 Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party Information

 Name \_\_\_\_\_ Mr.  Mrs.  Ms.  Dr.   
Last First Middle

 Residence \_\_\_\_\_ Home phone \_\_\_\_\_  
Street City State Zip

 Mailing Address \_\_\_\_\_ Work phone \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Cell phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Social Security No. \_\_\_\_\_ E-mail \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security No. \_\_\_\_\_ E-mail \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

## Dental Insurance Information

Insured's Name \_\_\_\_\_ Insured's Soc Sec No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

 Do you have dual coverage? Yes  No  If yes, please complete:

Insured's Name \_\_\_\_\_ Insured's Soc Sec No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group No. \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

## Emergency Contact Information

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

 Complete address \_\_\_\_\_  
Street City State Zip

Home phone \_\_\_\_\_ Other phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date and initial) \_\_\_\_\_

## Medical History

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Please check Yes or No. (If Yes, please fill in details)

Yes  No  Are you taking any medications? \_\_\_\_\_

Yes  No  Are you allergic to any medications? \_\_\_\_\_

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? \_\_\_\_\_

### For Female Patients Only:

Yes  No  Are you pregnant? \_\_\_\_\_

Yes  No  Has menstruation started? \_\_\_\_\_

Check any of the medical conditions below that you have had or currently have.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Abnormal bleeding/Hemophilia | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Hepatitis/Liver problems | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Herpes                   | <input type="checkbox"/> Prolonged Bleeding     |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma or Hay Fever          | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Rheumatic Fever        |
| <input type="checkbox"/> Bone Disorders               | <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Kidney Problems          | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Congenital Heart Defect      | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Nervous Disorders        | <input type="checkbox"/> Tumor or Cancer        |

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

## Dental History

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

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 day? \_\_\_\_\_

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, What is the 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 \_\_\_\_\_

**Benefits.** The benefits of orthodontics are 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 of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Apple Orthodontix to perform a complete orthodontic evaluation.

Signature \_\_\_\_\_ Date \_\_\_\_\_