

# Medical/Dental History

Date: \_\_\_\_\_

Patient's Name:	Sex:	Age:	Birthdate:
Prefers to be addressed by:	Referred by:		
Address:	City:	Zip:	Phone:
Your Occupation:	Work Phone:		
Your Employer:			
Spouse's Name:	Occupation	Work Phone:	
Spouse's Employer	Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Child's Name:	DOB:	Child's Name:	DOB:
Child's Name:	DOB:	Child's Name:	DOB:
Person Responsible for Account: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (State Name):			
Address:	Business Phone:	Home Phone:	

## DENTAL INSURANCE

Primary Insurance Co:	Gr. #:	Ortho. Coverage: YES NO
Insureds Name:	SS#:	Birthdate:
Secondary Insurance Co:	Gr. #:	Ortho. Coverage: YES NO
Insureds Name:	SS#:	Birthdate:
Other Insurance Information:		

## DENTAL HISTORY

Patient's Dentist:	Date of Last Visit:			
1. Have there been any injuries to the face, mouth or teeth?	YES NO			
2. Has the patient had or presently have any of the following habits? YES NO	Thumb or finger sucking Grinding of teeth at night	Lip Biting Mouth breathing	Snoring	
3. Has the patient been informed of any missing or extra permanent teeth?	YES NO			
4. Is the patient aware of sores, lumps or irritated areas in the mouth?	YES NO			
5. Has an orthodontist been consulted previously? Name: _____ Date: _____	YES NO			
6. Has the patient ever been treated for: If so, by whom: _____	YES NO	Bad Bite	TMJ	Periodontal disease
7. Does the patient have any speech problems?	YES NO			
8. Is the patient frightened or anxious about Orthodontic treatment?	YES NO			
9. Is the patient concerned about the appearance of their teeth?	YES NO			
10. Is there anything the patient would like to change about his/her smile? If so, what: _____	YES NO			
11. What aspect of dental treatment is the patient most concerned with?	Quality	Cost	Discomfort	Time
12. Reason for consultation:				
13. Has there ever been any orthodontic treatment for any other member of the family	YES	NO		
Are you satisfied with the results?	YES	NO		
Spouse (Dr. _____)	Child (Dr. _____)	Child (Dr. _____)	Child (Dr. _____)	

