



Chart Number _____

Date _____

PATIENT'S INFORMATION

Patient's Full Name _____ Name you like to be called by: _____
Last First Middle

Patient's Address _____
Street City State Zip

Patient's School _____ Grade In School _____ Home Phone _____

Patient's Date of Birth _____ Age _____ Male Female Single Married
Month Day Year

Patient's Dentist _____ Date last visited _____

Whom may we thank for referring you: _____

Name(s) and Age(s) of children or siblings: (1) _____, Age _____; (2) _____, Age _____; (3) _____, Age _____; (4) _____, Age _____

Has any member of the family undergone orthodontic treatment? _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone: _____

Previous Address (if less than three years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

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

Signature (parent or guardian's signature if minor) _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

HEALTH HISTORY

Medical History Updates _____

Please check if patient has, or has had...

- Joint Swelling or Arthritis
- Bone Disorders
- Heart Problems
- Diabetes
- Thyroid Problems
- Kidney Problems
- Rheumatic Fever
- Hepatitis or Liver Problems
- Emotional Problems
- Tuberculosis
- Aids (Acquired Immune Deficiency Syndrome)
- Anemia
- Asthma
- Epilepsy
- Prolonged Bleeding
- Endocrine Problems
- Tonsils Removed? If yes, when?
- Adenoids Removed? If yes, when?

List any allergies _____

Is the patient under a physician's care presently? _____

Name _____

Reason _____

List any medications being taken presently: _____

If so, list medication/dosage: _____

List any other serious illness and operation not listed above: _____

Please list your chief concern(s) and what you would like treatment to accomplish: _____

Does the patient require pre-medication prior to dental visits? _____

If so, list medication/dosage _____

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)

Dental History

Please check if patient has, or has had...

- Any injuries to face, mouth, teeth? (Circle)
- Thumb, finger or lip sucking habit(s)? (Previously/Currently) (Circle)
- Any speech problems?
- Mouth breathing when asleep, awake? (Circle)
- Any known missing permanent teeth?
- Any known extra permanent teeth?
- Any teeth removed by extraction? When?
- Is there a tongue thrust problem?
- Any wind instruments played?
- Any clenching or grinding of teeth? (Circle)
- Any chronically sore or bleeding gums?
- Any pain or popping or locking on opening or closing jaw movement? (Circle)
- Any difficulty in chewing or swallowing food? (Circle)
- Frequent Headaches? If yes, headaches per week? _____
- An muscle tenderness or stiffness in the jaw or neck? (Circle)
- Any ringing sounds in the ear, or spells of dizziness? (Circle)
- Any previous treatment for TMJ or jaw joint problems? If yes, explain.

Does patient visit his/her dentist regularly? _____

Has an orthodontist been consulted previously? _____

Reason _____

Has the patient experienced a sudden increase in height? Yes No

Does any member of the family or close relatives have similar arrangement of teeth or similar appearance of jaws? _____