Patient Information

Name_______________________________________Nickname______________Birthday____________Age____Gender ___

Address ____

Parent(s) Name(s)____Marital Status__________

Patient lives with ____ Is patient adopted?_____

Home Phone______________________________Mobile Phone_________________________Other phone _____________

E-mail Address ____

Father's Employer__________________________________Occupation______________________Phone________________

Mother's Employer_________________________________ Occupation______________________Phone________________

School__________________________________Grade_____Academic Average______Sports/ Interests _______________

Siblings: Ages__________________Have any family members been seen at our office? ___________________________

Whom may we thank for referring you?____

Responsible Party Information

Name____Relationship to patient _____________________________

Mailing Address ____

Home Phone______________________________Mobile Phone_________________________Other phone _____________

Dental Insurance Information

Insured's Name____Employer_______________________________________

Insurance Company___________________________ Group No.__________________ Local No. _______________________

Insurance Co. Address____ Phone No. ____________________

Social Security #________________________________ Birthdate__________________ Relationship to Patient ___________

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name____Employer ______________________________________

Insurance Company___________________________ Group No.__________________ Local No. _______________________

Insurance Co. Address____ Phone No. ____________________

Social Security # _____________________________ Birthdate __________________ Relationship to Patient ___________

Emergency Information

Name of preferred emergency contact ____

Address ____

Phone number_____________________________________Relationship to patient __________________________________

Updates (date and initial)______________ ______________ ______________

Please complete BOTH sides of form

PATIENT'S MEDICAL HISTORY

Physician____ Date of Last Visit __________________________

Address____Phone __________________________

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

Yes No Taking any medication? ____
Yes No Allergic to any medication? ____
Yes No History of a major illness? ____
Yes No Major operation(s)? ____
Yes No Serious accident(s)? ____

Circle any of the medical conditions below that your child has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any other medical conditions that you feel we should be aware of?____________________________________

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PATIENT'S DENTAL HISTORY

Dentist ____ Date of last Cleaning ________________________

What concerns you most about your child's teeth? ____

Yes No Is your child presently in any dental pain? ____
Yes No Has your child ever experienced any unfavorable reaction to dentistry? _________________________
Yes No Has your child ever lost or chipped any teeth? ____
Yes No Has your child suffered any injuries to face, mouth or teeth? _________________________________
Yes No Is any part of your child's mouth sensitive to temperature or pressure? __________________________
Yes No Do your child's gums bleed when you brush? ____
Yes No Does your child have any type of thumb or tongue habit?___________________________________
Yes No Is your child a mouth breather? ____
Yes No Has your child ever seen an orthodontist? If yes, who and when? ______________________________
Yes No Will your child object to wearing orthodontic appliances (braces) should they be indicated? ____________
Yes No Has anyone in your family received orthodontic treatment? ___________________________________
Yes No Do your child's teeth or jaws ever feel uncomfortable when he/ she wakes in the morning?____________
Yes No Are you aware of your child's jaw clicking or popping? ______________________________________
Yes No Are you aware of your child clenching his /her teeth during the day? ____________________________
Yes No Have you ever heard your child grind his/ her teeth? _______________________________________
Yes No Does your child suffer "tension" headaches?____
Yes No Has your child ever experienced chronic ringing in his/ her ears? ______________________________
Yes No If the patient is under age 16, height of parents? Mom______ Dad______
Yes No Are you aware that some appointments will be during school/work hours? ________________________

Female Patients only:

Yes No Could your child be pregnant? ____
Yes No Has menstruation started?____

BENEFITS AND LIMITATIONS

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 may have an atypical response 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 understand that my diagnostic records may be used for educational and training purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Chapel Hills Orthodontics to perform a complete orthodontic evaluation.

Signature:__________________________________ Relationship to patient ________________ Date _________

Updates (date and initial)____________ ____________ ____________