Patient Full Name: _____

Patient Information Sheet

Nickname: _____

Patient Full Address:_____

Home Phone: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify)_____

Cell Phone: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify)_____

Email: _____

Birthday: _____Age: _____ Sex: _____

School/Employer: _____ Grade/Position: _____

Interests/Sports: _____

Names of Brothers and Sisters, Age: _____

Primary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Responsible Party: _____ Telephone: _____

Full Address: _____ How Long? _____

Employer: _____ Telephone: _____

Secondary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Responsible Party: _____ Telephone: _____

Full Address: _____ How Long? _____

Employer: _____ Telephone: _____

Whom may we thank for referring you to Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other _____

Present Dentist: _____ Date of Last Cleaning:_____

Reason for Consult:_____

Physician: _____ Date of Last Visit:_____ Phone number:_____

Circle Yes or No for which the patient has a history:

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	Tooth Grinding	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tuberculosis	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Venereal Disease	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Thumb Habit	YN
Aspirin	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Osteoporosis	YN
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N		
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N		
Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Speech problems	Y N		
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	TMJ problems	Y N		

Any disease, problems, or allergies not mentioned above?

_____

Current Medications? _____

Females: Have you started menstruating: Y N At What age? _____

Have wisdom teeth been extracted? Y N If yes when: _____Any face, mouth or teeth injuries:_____

Does patient normally breathe through the mouth while awake or asleep: _____Do gums bleed when brushed or flossed?

_____

Has an orthodontist been consulted previously _____ Have you had previous orthodontic treatment? Y N if yes when:_____

Are there any missing or extra teeth? Y N Have tonsils and adenoids been removed? _____

Are you aware that some appointments will be during work/school hours: Y N
Any other questions? _____

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of PRIMARY Policy Holder: _____Telephone: _____

Insurance Address:_____

Policy Holders Birthday: _____ Social Security Number: _____

Name of SECONDARY Policy Holder: _____Telephone: _____

Insurance Address:_____

Policy Holder Birthday: _____ Social Security Number: _____

Benefits and Limitations

Orthodontics is a service that provides an improvement in the appearance of the teeth, in 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 the 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 change in my medical or dental history. In addition, I authorize Chapel Hills Orthodontics to perform a complete orthodontic evaluation.

Signature:_____Relationship to patient:_____ Date:_____