## 1. Patient Information

Todays's date_____ M_____ F____
Name:_____
*last* *first* *m*
Nickname_____ SS# _____
Birth Date:_____Age: _____
Home Phone#: (___) _____
Home Address_____
_____
*city* *state* *zip*
Height_____Weight_____
Referred by:_____
General Dentist_____
Last visit date:_____
Patient marital status: Single Married
Separated Widowed Divorced

## 2.) Spouse Information

Name:_____
Address:_____
Home Phone # (___) _____
Work Phone # (___) _____
Employer:_____
Occupation:_____
SS#_____

## 3). Responsible Party

Name:_____
Relation:_____
BillingAddress:_____
E-MailAddress:_____
Home Phone # (___) _____
Work Phone # (___) _____
Employer:_____
Occupation:_____
SS#_____

## 5).Primary Orthodontic Insurance

Orthodontic Coverage? Yes_____ No_____
Insurance Co. Name:_____
Insurance Co. Address:_____
Insurance Co. Phone #: (___) _____
Group# (Plan, Local, or Policy #):_____
Policy Owner's Name:_____
Relationship to Patient:_____
Policy Owner's Birth Date:_____
SS#_____
Policy Owner's Employer:_____
_____

## 6. MEDICAL HISTORY

| | | |
|---|---|---|
| Y | N | Abnormal bleeding |
| Y | N | Allergies to any Drugs |
| Y | N | Allergic to Latex or Metals |
| Y | N | Allergic to Plastics |
| Y | N | Anemia |
| Y | N | Asthma |
| Y | N | Bone Disorders |
| Y | N | Cancer |
| Y | N | Colds/Sore Throats |
| Y | N | Congenital Heart Defects |
| Y | N | Convulsions/Epilepsy |
| Y | N | Diabetes |
| Y | N | Endocrine Problems |
| Y | N | Fainting or Dizziness |
| Y | N | Handicaps/Disabilities |
| Y | N | Hearing Impairment |
| Y | N | Heart Trouble/Murmur |
| Y | N | Hemophilia |
| Y | N | Hepatitis |
| Y | N | HIV+/AIDS |
| Y | N | Kidney/Liver Problems |
| Y | N | Liver Involvement |
| Y | N | Major Illness |
| Y | N | Nervous Disorders |
| Y | N | Pneumonia |
| Y | N | Rheumatic/Scarlet Fever |
| Y | N | Seasonal Allergies |
| Y | N | Tonsils/Adenoids Removed/Age?_ |
| Y | N | Tuberculosis |

Drugs that you are allergic to: _____
_____
Drugs now being taken /reason:_____
_____

# Dental History

Family Dentist_____ Date of last dental visit_____

No. of checkups per year ( ) Once ( ) Twice ( ) Only if urgent ( ) Never
Have you had a previous orthodontic consultation or treatment? ( ) No ( ) Yes
Date: _____

| History of: | | | If yes, mark those that apply: | Please explain |
|---|---|---|---|---|
| Tooth injury | ( )No | ( )Yes | ( )Chipped ( )Broken ( )Lost | _____ |
| Oral Disease | ( )No | ( )Yes | ( )Decay ( ) Ulcers ( )Sores | _____ |
| Jaw Joint Noises | ( )No | ( )Yes | ( )Right ( )Left ( )Both | _____ |
| Grinding your teeth | ( )No | ( )Yes | ( )During day ( )When sleeping | _____ |
| Clenching your teeth | ( )No | ( )Yes | ( )During day ( )When sleeping | _____ |
| Bleeding gums | ( )No | ( )Yes | ( )Usually ( )Sometimes ( )When brushing ( )Flossing | |
| Oral habits | ( )No | ( )Yes | ( )Thumb/finger sucking ( )Tongue thrusting ( )Other | |
| Airway Problems | ( )No | ( )Yes | ( )Mouth breathing ( )Other | |
| Speech therapy | ( )No | ( )Yes | If yes, advised by:_____ | |

Why did you seek this consultation?

| | | |
|---|---|---|
| ( ) To correct overbite | ( )Crowding | ( )Jaw dysfunction |
| ( ) Eliminate facial pain | ( )Close spaces | ( )Improve facial proportions |
| ( ) Improve general appearances | ( )Improve facial proportions | ( )Other:_____ |

Orthodontic consultation prompted by:
( )Patient ( )Dentist ( )Hygienist ( )Friend ( )Other

Tell us about you !!!!!!!!!!!!

Do you have plans for other dental work? ( )Root Canal Therapy ( )Bridges ( )Crowns ( )Restorations ( )Cosmetic
If so please explain_____
How do you feel about braces? _____
Any specific hobbies? _____
Do you play a musical instrument? _____
Do you play any sports? _____

I certify that I have reviewed the above medical/dental history and it is accurate to my knowledge at this time. If there are any future changes in this information I will inform Drs.Weidman and Hazey III.

_____

Signature Date