

## MEDICAL HISTORY

### PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

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|--|---|
| <input type="checkbox"/> Joint Swelling              | <input type="checkbox"/> Anemia                 |
| <input type="checkbox"/> Bone Disorders              | <input type="checkbox"/> Epilepsy (Convulsions) |
| <input type="checkbox"/> Heart Trouble               | <input type="checkbox"/> Prolonged Bleeding     |
| <input type="checkbox"/> Mitral Valve Prolapse       | <input type="checkbox"/> Faintness/Dizziness    |
| <input type="checkbox"/> Rheumatic Trouble           | <input type="checkbox"/> Tonsils Removed        |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Adenoids Removed       |
| <input type="checkbox"/> Emotional Complications     | <input type="checkbox"/> Sore Throat            |
| <input type="checkbox"/> Autism                      | <input type="checkbox"/> Tonsillitis            |
| <input type="checkbox"/> ADD/ADHD                    | <input type="checkbox"/> Earaches               |
| <input type="checkbox"/> Turrets                     | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Other _____                 | <input type="checkbox"/> Metal/Nickel Allergy   |
| <input type="checkbox"/> Brain Injury                | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Kidney or Liver Involvement | <input type="checkbox"/> Peanut Allergy         |
| <input type="checkbox"/> Joint Prosthesis            |   |
| <input type="checkbox"/> Tuberculosis                |   |

### HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:

- Y  N Rheumatoid Arthritis?  
 Y  N Lupus?

Y  N Do you have a latex allergy?

### ARE YOU PREGNANT?

Y  N

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION

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### Is patient presently under physician care for any reason?

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Name of primary physician \_\_\_\_\_

Other \_\_\_\_\_

List any other serious illnesses \_\_\_\_\_

Adolescent Females: Has menstruation begun?

Date: Month/Year \_\_\_\_\_

Approximately how much has the patient grown the last year?

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## DENTAL HISTORY

General Dentist \_\_\_\_\_

Last Cleaning \_\_\_\_\_

### PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

- Any injuries to face, mouth or teeth  
 Thumb, finger or lip sucking  
 More than average amount of tooth decay  
 Extra permanent teeth  
 Teeth removed by extraction  
 Difficulty in swallowing or chewing  
 History of gum problems  
 Previous orthodontic treatment

When \_\_\_\_\_

Where \_\_\_\_\_

Dental treatment recommended by DDS that is not done.

When is it scheduled? \_\_\_\_\_

Grinding  TMJ  Clenching

Does patient require pre-medication?  Y  N

Is patient a mouth breather?  Y  N

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION

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Does patient make any noises while sleeping?  Y  N

More than normal ear infections or stuffy nose?  Y  N

Does either parent have sleep apnea?  Y  N

List drugs or medications now being taken

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Do you take any medications for osteoporosis?  Y  N

If yes, please list: \_\_\_\_\_

List any allergies \_\_\_\_\_

What do you want to accomplish with orthodontic treatment?

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Patient's attitude toward orthodontic treatment:

Very Motivated  Will Cooperate If Needed  Not Motivated

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

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date and Initial) \_\_\_\_\_

### Minor Patient Information

(Adult Patient Use Box Below)

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

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information / Adult Patient

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_

Mailing Address \_\_\_\_\_

How Long at this address \_\_\_\_\_  Rent  Own

Previous Address (if less than 3 years) \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Number years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Insured's Name \_\_\_\_\_ Insured's ID # \_\_\_\_\_  
Last First Middle

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

Insured's Employer \_\_\_\_\_

I authorize payment to Braces For All Ages, PC \_\_\_\_\_

Do you have dual coverage?  Yes  No If yes: Insurance Co. Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's ID # \_\_\_\_\_  
Last First Middle

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_

I authorize payment to Braces For All Ages, PC \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Relationship \_\_\_\_\_