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ORTHODONTICS ON THE PLATEAU
Live. Dream. Smile.

Patient Information

Patient's Name:_____ Date:_____
Last First Nickname

Male/Female Birth Date:_____ Age:____ Patient Cell Phone:_____ Text Reminder? Y / N
Circle One

Residence:_____
Street City State Zip Code

E-mail:_____

If patient is a minor, accompanying parent/guardian name:_____
Last First Relationship to Patient

Whom may we thank for referring you to our office?_____

Responsible Party Information

Name: _____
Last First E-mail

Residence:_____
Street City State Zip Code

How long?___yrs Home Phone:_____ Cell Phone:_____ Work Phone:_____

Relationship to Patient:_____ Marital Status:_____

Employer:_____ Occupation:_____ No. Years Employed:_____

Spouse or Other Parent Name:_____
Last First E-mail

Employer:_____ Occupation:_____ No. Years Employed:_____

Relationship to Patient:_____

Orthodontic Insurance Information

Insured's Name:_____ SSN# or ID#:_____
Last First

Insurance Company:_____ Group No. :_____ Ins. Co. Phone:_____

Insured's Employer:_____ Insured's Birth Date:_____

Do you have dual coverage? Y / N
Circle One

Insured's Name:_____ SSN# or ID#:_____
Last First

Insurance Company:_____ Group No. :_____ Ins. Co. Phone:_____

Insured's Employer:_____ Insured's Birth Date:_____

Emergency Information

Name of nearest relative not living with you:_____ Phone:_____

Address_____ Relationship:_____
Street City State Zip Code

To the best of my knowledge all information is correct.

*Patient Signature (parent's signature if minor):*_____

Medical History

Physician Name/Phone _____ Last Medical Exam _____

Is Patient in Good Health? ☐ Yes ☐ No Reason _____

Currently taking any medications? ☐ No ☐ Yes List _____

Is patient being treated by a physician now? ☐ No ☐ Yes Reason: _____

Allergies to: ☐ Penicillin ☐ Ibuprofen ☐ Latex ☐ Anesthetic ☐ Nuts/Food _____ ☐ Other _____

Has the patient ever been diagnosed or treated for any of the following?

☐ Abnormal blood pressure	☐ Bleeding Problems	☐ Epilepsy	☐ Rheumatic Fever
☐ ADD/ADHD	☐ Bone/ Growth Disorders	☐ Headaches/Migraine	☐ Sinus trouble or hay fever
☐ AIDS/HIV Positive	☐ Cancer or Leukemia	☐ Heart disease/Murmur	☐ Stomach problems
☐ Anemia	☐ Connective Tissue Disorder	☐ Hepatitis or liver issues	☐ Tuberculosis or lung disease
☐ Arthritis	☐ Developmental	☐ Herpes/ Cold Sores	☐ Thyroid Problems
☐ Asthma/breathing Issues	☐ Diabetes	☐ Hypoglycemia	☐ Ulcers

If yes, please explain: _____

Any other major or unusual illnesses? Explain: _____

Pregnant? ☐ Yes ☐ No If yes, how far along? _____

Dental History

General Dentist _____ Last Visit Date _____

Has the patient had, or have you noticed any of the following?

- ☐ Traumatic injury to teeth, mouth, or face
- ☐ Tonsils or adenoids removed, age _____
- ☐ Pain or tenderness in jaw joint, ear, side of face
- ☐ Thumb/finger sucking
- ☐ Clicking, locking or popping of jaw joint
- ☐ Brushing/flossing difficulties
- ☐ Extractions of primary or secondary teeth
- ☐ Traumatic dental experience
- ☐ Clenching or grinding of teeth
- ☐ Missing or additional teeth
- ☐ Nail biting
- ☐ Mouth breathing
- ☐ Teeth sensitive to hot, cold, sweets or pressure
- ☐ Difficulty chewing or eating
- ☐ Speech problems/tongue thrust

If yes, explain _____

Has the patient ever been evaluated for orthodontic treatment? _____

Has the patient ever had orthodontic treatment? _____

Patient's Attitude toward orthodontic treatment? : ☐ Eager ☐ Complacent ☐ Not Enthusiastic

For Patients Under 18 Years of Age

Father's height _____ Mother's height _____ Adopted? ☐ Yes ☐ No

Has Puberty begun? ☐ No ☐ Yes Girl's First Menstruation Age _____ Boy's Voice Change Age _____

School _____ Grade _____ Hobbies _____

Sports Played _____ Instruments Played _____

List brothers / sisters with age: _____

Have siblings or parents had orthodontic treatment? ☐ Yes ☐ No Friends that are patients _____