Confidential Patient Information			
First Name:	Middle Initial:	Last Name:	
Nickname:	Birthdate:	Gender:	
Address:	City:	State:	Zip:

Main Phone:	2nd/Cell Phone:	Email:	Social Security #:
If patient is a minor, give parent/guardian's name:		If patient is a minor, who does the patient live with?	
Please list the names of any friends or family currently in the practice:			
List any sports, hobbies or musical instruments played:		Whom may we thank for referring you to our practice?	
School:		Grade:	

Financial Party Information			
First Name:	Middle Initial:	Last Name:	
Marital Status:	Relationship to Patient:	Birthdate:	
Address:	City:	State:	Zip:

Email:	Main Phone:	2nd/Cell Phone:	Work Phone:
Social Security #:	Employer:	Occupation:	Length of Employment:
Spouse/Other Parent's First Name:	Middle Initial:	Last Name:	
Relationship to Patient:	Social Security #:	Birthdate:	
Employer:	Occupation:	Length of Employment:	Work Phone:

Dental Insurance Information		
Policy Holder's Name:	Relationship to Patient:	Policy Holder's Employer:

Insurance Company Name:	Subscriber ID:	Group Number:	
Insurance Company Address:	City:	State:	Zip:
Insurance Company Phone:			
Do you have dual dental coverage? (If yes, complete information below.)			
Policy Holder's Name:	Relationship to Patient:	Policy Holder's Employer:	
Insurance Company Name:	Subscriber ID:	Group Number:	
Insurance Company Address:	City:	State:	Zip:
Insurance Company Phone:			

Emergency Information	
Name of nearest relative not living with you:	Complete Address:
Phone:	Relationship to Patient:

Dental History		
Dentist Name:	Check-up Frequency:	Last Dental Visit:
Has the patient had an orthodontic consult or treatment? If so, when?		
What type of toothbrush does the patient use?		
Is the patient interested in Invisalign, braces, or both?		
Does the Patient need to premedicate prior to dental visit?		
What is the patient's main orthodontic concern?		

Please mark YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.

Speech problems/therapy?		Clench or grind teeth?	
Oral habits (thumb/finger sucking, lip/nail biting)?		Injury to face jaw, teeth or mouth?	
Discomfort from teeth or gums?		Pain, tenderness or noise in either jaw?	
Frequent headaches?		Chipped or injured permanent teeth?	
Teeth sensitive to hot or cold?		Previous root canal therapy?	
Previous periodontal (gum) treatment?		Abnormal swallowing (tongue thrust)?	
Teeth that irritate tongue, cheek, lip, etc.?		Numerous fillings?	

Brush teeth daily?		Floss teeth daily?	
Fluoride treatments?		Mouth breathing?	
Snores during sleep?		Any missing or extra permanent teeth?	
Apprehensive about dental care?		Frequently chew gum?	
Thumb or finger habit as a child?		Jaw fractures, cysts, moth infections?	
Bleeding gums?		Other periodontal (gum) problems?	
Frequent canker sores or cold sores?		Have wisdom teeth been removed?	
Problems with food trapped between teeth?		S all dental work completed at this time?	
Have you had a TMJ screening?		Do you have a history of jaw joint problems?	
Have you been treated for "TMJ"?		Do you notice clicking or popping in your jaw joint?	
Do you clench your teeth?		Has your jaw ever locked?	
Do you have difficulty chewing or opening your mouth?		Does your bite feel uncomfortable or unusual?	
Do you experience soreness in the muscles of your face or around your ears?			
If any of the above TMJ questions were answered 'Yes', please explain:			

Medical History			
Physician Name:	Date of Last Physical:	Patient Health:	
Address:	City:	State:	Zip:
Has there been any change in the patient's general health within the last year?			
Is the patient now under the care of a physician (other than routine)? If so, what is being treated?			
Has the patient had a serious illness/hospitalization in the past 5 years? If so, what for?			
List any medications currently being taken by the patient (include non-prescription):			

Allergies or drug reaction to:

Latex		Penicillin or other antibiotics		Sulfa drugs	
Aspirin, Ibuprofen, Tylenol		Local anesthetics		Codeine or other narcotics	
Metal Allergy		Other			
List any drug allergies or sensitivities (not listed above) that the patient may have:					

Please mark YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.					
Heart Murmur		Damaged or artificial heart valves		Congenital Heart Defect	
Heart Disease		Rheumatic Fever		Angina	
Liver Disease / Jaundice / Hepatitis		Kidney Disease		Heart Attack/Stroke	
Hemophilia		Hypertension/High Blood Pressure		Prolonged Bleeding/Transfusion	
Anemia / Blood disorder		HIV/AIDS		Tonsils/Adenoids Removed	
Handicaps/Disabilities		Arthritis / Joint problems		Large Tonsils	
Sinus trouble		Bed wetting		Substance abuse problem (past or present)	
Bone fractures/trauma to face/jaw		Prosthetic joints		Chronic fatigue	
Diabetes		Growth Problems		Tuberculosis or Lung Disease	
Pneumonia		Cancer		Family History of Cancer	
Received Radiation Treatment		Arteriosclerosis		Thyroid / Endocrine Problems	
Stomach ulcer or hyperacidity		Hormone Therapy		Nervous Disorders	
Bone Disorders/Bone Loss		Seizures / Epilepsy / Neurological Disease		Treated for Emotional Problems	
Asthma		Respiratory problems / Emphysema		Persistent swollen neck glands	
Sexually transmitted disease		Low blood pressure		Persistent cough	
FEMALES: Are you pregnant		Take Bisphosphonates (Fosamax, Boniva)		Birth Defects / Hereditary Problems	

Patient Motivation for Orthodontic Treatment	
How would you change your teeth	
How would you change your facial appearance	
Where would you like to reduce the pain or discomfort	

Patients Under 18			
Height:		School:	
Weight:		Grade:	
Has patient begun puberty			
If girl, has menstruation begun			
If boy, has voice changed or have facial hair			

Has the patient grown in the past year or has their shoe size changed recently
Has either biological parent ever had orthodontic treatment?
I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.
I understand that where appropriate, credit bureau reports may be obtained.