# *WELCOME TO OUR OFFICE*

DATE_____
Updated _____
Updated _____

PATIENT'S NAME_____NICKNAME_____

D.O.B._____AGE_____ SEX M_____ F_____

ADDRESS_____TOWN_____STATE_____ZIP_____

HOME PHONE:_____ Cell/Work PHONE_____

OCCUPATION _____EMPLOYED BY_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

DO YOU HAVE AN *ORTHODONTIC* INSURANCE PLAN? YES___ NO_____

NAME OF INSURANCE COMPANY?_____
GROUP #_____

(note: We ONLY accept DELTA DENTAL ins. but we will provide you with a "superbill" for you to send into your particular insurance company)

GENERAL APRAISAL Who can we thank for your referral?_____

CHIEF COMPLAINT (REASON FOR CONSULTATION)_____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? _____NO _____YES IF YES,

EXPLAIN_____

**MEDICAL HISTORY**

PHYSICIAN _____ LAST EXAM _____

CURRENTLY UNDER MEDICAL TREATMENT ____NO YES__ explain _____
HISTORY OF RECENT ILLNESS ____NO YES__ explain _____
CURRENTLY TAKING MEDICATION ____NO YES__ explain _____
EVER BEEN HOSPITALIZED ____NO YES__ explain _____
EVER HAD AN OPERATION ____NO YES__ explain _____
ALLERGIC TO MEDICATIONS ____NO YES__ explain _____
ANY OTHER ALLERGIES ____NO YES__ explain _____

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DO YOU HAVE A HISTORY OF:

____ANEMIA ____BONE DISORDERS _____EPILEPSY
____ASTHMA ____KIDNEY DISORDERS _____RHEUMATIC FEVER
____DIABETES ____LIVER INVOLVEMENT _____BLEEDING

PROBLEMS:

____HEART ____FAINTING OR DIZZINESS
_____ENDOCRINE DISORDERS

EXPLAIN _____

**DENTAL HISTORY**

DENTIST _____ _____LAST EXAM_____

___ THUMB/FINGER SUCKING UNTIL AGE _____
___ MOUTHBREATHING _____AWAKE _____ASLEEP
___ GRINDING OR CLENCHING ____DAY ____NIGHT
___ NAIL-BITING
___ LIP BITING/LICKING
___ BLEEDING GUMS
___ INJURIES TO FACE/MOUTH/TEETH
___ SORENESS OR CLICKING IN JOINT ____NO ____YES

HOW FREQUENTLY DO YOU USE FLOSS _____

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? _____

ANY FURTHER COMMENTS: