FAMILY ORTHODONTICS

Welcome! *At Family Orthodontics, we treat people, not just teeth. We care about your total health and appreciate your time in completing this confidential health history.*

Date:_____ Updated:_____

PATIENT INFORMATION

Patient's Name_____ I prefer to be called_____
Last First Middle

Address_____ Gender_____ Age_____
Street City Zip

Home Phone _____ Cell Phone_____ Birth date _____
Email Address_____ School_____ Grade _____
Hobbies/Interests/Pets_____
Siblings/Children? Names (Ages)_____
Emergency Contact_____ Phone_____ Relationship _____
Whom may we thank for your referral? _____
What concerns you most about your teeth? _____
_____

CUSTODIAL PARENT/GUARDIAN (IF PATIENT IS A MINOR CHILD)

Name_____ Relation to patient _____
Last First Middle

Address_____ Email_____
Street City Zip

Home Phone _____ Cell Phone_____ Work Phone _____

FINANCIAL INFORMATION FOR RESPONSIBLE PARTY

Name_____ Relation to patient _____
Last First Middle

Address_____ Email_____
Street City Zip

Home Phone _____ Cell Phone_____ Work Phone _____
Social Security # _____ Birth date _____ Years with current employer_____
Employer _____ Occupation _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____
Insured's Address _____
Insured's Employer _____
Insured's Employer Address _____
Insurance Company _____ Group # _____ Local # _____
Insurance Co. Address _____ Phone _____ Fax _____

-- OVER --

10261 ROUTE 60, SUITE 2 ▪ FREDONIA, NY 14063 ▪ P 716.672.2002 ▪ F 716.672.2012

MEDICAL HISTORY

Physician _____ Date of last visit _____ Reason _____
Address _____ Phone _____

Please circle **Yes** or **No** (if Yes, please fill in details):

Yes No Do you have any food, drug, or other allergies?_____
Yes No Are you allergic to latex or nickel?_____
Yes No Are you taking any medications?_____
Yes No Are you presently or have you ever been a smoker?_____
Yes No Do you have a history of a major illness?_____
Yes No Have you ever been hospitalized?_____
Yes No Do you require pre-medication prior to dental procedures?_____
Yes No Are you having any problems at work or in school? _____

Circle any of the following conditions you have presently or have had in the past:

Abnormal bleeding	Congenital heart defect	Heart murmur	Pneumonia
Adenoids removed	Diabetes	Heart problems	Prolonged bleeding
Anemia	Dizziness	Hepatitis/Liver problems	Radiation/Chemo
Arthritis	Epilepsy	Herpes	Rheumatic fever
Asthma/Allergies	Fainting	High blood pressure	Tonsils removed
Bone disorders	Growth disorders	Nervous disorders	Tuberculosis

Are there any conditions not discussed that we should be aware of?_____
_____

DENTAL HISTORY

Dentist Name _____ Date of last visit _____ Reason _____

Yes No Have you ever seen an orthodontist? If yes, who and when?_____
Yes No Have you ever chipped or lost any teeth?_____
Yes No Have there been any injuries to the mouth, face, or teeth?_____
Yes No Have you any missing permanent teeth? _____
Yes No Have you ever had a tooth extracted? _____
Yes No Have you any difficulty chewing or swallowing? _____
Yes No Have you any type of finger, thumb, or tongue habit? _____
Yes No Has anyone in your family received orthodontic treatment? _____
Yes No Do you ever experience any discomfort in your teeth or jaws? _____
Yes No Are you aware of any clicking or popping in your jaws? _____
Yes No Do you have any oral habits (clenching, grinding, nail biting, etc)? _____
Yes No Females only: Are you or may you be pregnant? _____

Circle the patient's attitude toward orthodontic treatment: Very motivated Will cooperate Not motivated
Are there any other health, behavioral, or dental issues not discussed that we should be aware of? _____
_____

"I have truthfully and completely answered all of the above questions and agree to inform this office of any changes. I consent to an orthodontic evaluation including photographs, radiographs, and examination."

Signature _____ Print name _____

Relationship to patient _____ Date _____

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