Patient Information

Name: _____

I prefer to be called: _____ Birthdate: _____ Male: _____ Female: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home #:_____ Cell #:_____ SS#:_____

Email: _____

Employer: _____

Occupation: _____ How long: _____

Work #: _____ Ext: _____

Where/when is the best time to reach you?: _____

Emergency Contact: _____

Phone: _____

Ethnicity: ___ Caucasian ___ African American ___ American Indian ___ Asian ___Hispanic ___ Other:_____

What are your main concerns that you would like orthodontics to accomplish?

_____

Have you ever been evaluated for orthodontic treatment? Yes___ No___

Whom may we thank for referring you? _____

Dental History

General Dentist:_____ Date of Last Exam: _____

Do you have any dental concerns at this time?_____

Your current dental health is: Good ____ Fair ____ Poor ____

Yes No _____ Have there ever been any injuries to the face, mouth, teeth or chin?
-If yes, please explain_____

Yes No Do you have any missing or extra permanent teeth?
-if yes, please explain_____

Yes No Do you generally breathe through you mouth? If yes: While awake? ____ While asleep? ____

Yes No Do you like your smile?

Yes No Do your gums ever bleed?

Yes No Have you ever had a serious/difficult problem with any previous dental work?

Yes No Does your child now have or ever experienced pain or discomfort in their jaw joint (TMJ/TMD)?

(Continued on back)

Medical History

Physician: _____ Phone: _____

Your current medical condition is: Good ____ Fair ____ Poor ____

Are you currently under the care of a physician?: Yes ____ No ____

If yes, please explain: _____

Please list all drugs you are currently taking: _____

Please list all drugs/materials you are allergic to: _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia
Allergy to Latex/Metals
Anemia
Arthritis
Artificial Bones/ Joints/ Valves
Asthma or Hay fever
Blood Transfusion
Bone Disorders
Congenital Heart Defect
Diabetes
Difficulty Breathing
Dizziness
Drug or Alcohol Abuse
Emphysema
Epilepsy/ Seizures/ Fainting
Fever Blisters/ Herpes
Gastrointestinal Disorders
Glaucoma
Heart Attack
Heart Murmur
Heart Surgery/ Pacemaker
Hepatitis/Liver problems
Hemophilia
High/ Low Blood Pressure
HIV+ / Aids
Hospitalization
Kidney problems
Mitral Valve Prolapse
Nervous Disorders
Pneumonia
Prolonged Bleeding
Psychiatric Problems
Radiation/Chemotherapy
Rheumatic Fever
Shingles
Sinus Problems
Severe/ Frequent Headaches
Tuberculosis
Tumor or Cancer
Ulcers/ Colitis

Are you pregnant? Yes ____ No ____

Please list any serious medical conditions that you have ever had had: _____

_____

_____

Acknowledgement

The information provided is correct to the best of my knowledge. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Nathan Thomas to perform a complete orthodontic evaluation.

Signature: _____ Date: _____