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Member
American Association of Orthodontists

Today's Date _____

Welcome to Our Office

Orthodontic Patient Information and Health History

Patient Name_____Age_____Birthdate_____Gender_____

Patient's preferred Name _____School Name _____Grade_____

Mailing Address_____Home Phone_____

City, State, Zip_____Cell Phone _____

Dentist _____ Referred By_____

Has the patient had any unusual dental experiences? Yes No Please Specify: _____
_____

Date of Last Dental Check Up? _____ Were the Patient's Teeth Cleaned? Yes No

Minor Patients: Father Mother

Name: _____ _____

Home Address: _____ _____

_____ _____

Phone Number: _____ _____

Social Security #: _____ _____

Employer's Name: _____ _____

Occupation: _____ _____

Business Phone #: _____ _____

Parents Marital Status: Single Married Separated Divorced Widowed

Whom do we Contact for Appointment Reminders? _____

To determine the possible growth of your child during orthodontic treatment, please answer the following questions as best as possible:

Father's Height _____ Mother's Height _____ Patient's Height _____ Patient's Weight _____

Patient Resembles: Father Mother Neither Patient's Past Year's Increase in Height: _____

Boys: Voice Changed? YES NO Girls: Menstruation Started? YES NO
When? _____ When? _____

ADULT Patients: Employer's Name: _____

Occupation: _____ Business Phone #: _____

Social Security #: _____ Marital Status: _____

Name of Spouse: _____ Spouse Occupation: _____

Social Security #: _____ Spouse Work Phone #: _____

Person Responsible for Payments on Account: Name: _____
Cell Phone #: _____ Home Phone #: _____ Work Phone #: _____
Address: _____ Email: _____

Is Patient Covered by Orthodontic Insurance? YES NO Subscriber's Name: _____
Social Security #: _____ Date of Birth: _____ Max Benefit: _____
Employer's Name: _____ Insurance Company: _____
Insurance Company Address: _____

Signature of individual completing this form: _____
If the person signing this form is not the patient, then what relation are you to the minor patient? _____

OVER PLEASE

Medical History

Has the patient ever had: (please circle all that apply)

AIDS	Cold Sores	Head or Face Injury	Lung Disease
Allergies	Diabetes	Hepatitis	Oral (mouth) Ulcers
Anemia	Endocrine Problems	Herpes	Rheumatic Fever
Arthritis	Epilepsy/Seizures	HIV	Surgery
Asthma	Hearing Problems	Jaundice	Thyroid Problems
Bleeding	Heart Condition	Kidney Disease	Tuberculosis

Other: _____ Comments: _____

Is the Patient pregnant? YES NO If so Due Date: _____

Has the patient been under the care of a physician during the past 2 years, other than for routine examination? YES NO If so please explain: _____

Does the patient require premedication for orthodontic procedures? YES NO

If so, please list the name of premedication needed: _____

Birth Defects: _____

Prescriptions patient is currently taking: _____

Is patient allergic to Penicillin? YES NO Any other Drugs? YES NO

If Yes Please List: _____

Respiratory History

Does the Patient: (Please Circle what applies)

1.	Have allergies:	Seasonal Grasses	Latex	Drugs	Other
2.	Breathe through mouth?		Seldom	Sometimes	Usually
3.	Snore when sleeping?		Yes	No	
4.	Have frequent colds?		Yes	No	
5.	Have frequent "stuffy nose"?		Yes	No	
6.	Have frequent sore throat/tonsillitis?		Yes	No	
7.	Have chewing/swallowing difficulties?		Yes	No	
8.	Headaches (more than normal)?		Yes	No	

Has the patient received medical treatment from an Allergist or ENT Specialist? Yes No

If Yes By Whom: _____ Treatment Date: _____

Nasal Surgery: Yes No Tonsils/Adenoids Removed: Yes No If Yes, When: _____

Dental and Temporomandibular Joint History

Has the patient ever had treatment for T. M. J. (jaw joint) problems? Yes No

Has the patient been in an accident involving the face and or jaw? Yes No

If Yes, to any of the above please provide date: _____

Does the patient experience:

1.	Difficulty with opening mouth?	Yes	No
2.	Pain or clicking in the jaw joint?	Yes	No
3.	Pain when chewing, yawning, or opening wide?	Yes	No
4.	Pain in or around the ears and or cheeks?	Yes	No
5.	A bite that feels "uncomfortable" or "unusual"?	Yes	No
6.	Locking of the jaw, "gets stuck", "catches", or "goes out"?	Yes	No
7.	Noises in or from the jaw during movement?	Yes	No

The following habits are of interest to the Doctor concerning treatment.

Please circle all that apply and provide appropriate information:

1.	Thumb /Finger/Lip sucking	Yes	No	Until age _____
2.	Grinding or clenching of teeth	Yes	No	Until age _____
3.	Tongue Thrusting or other functional problems	Yes	No	Until age _____

Has the patient received a previous Orthodontic Consultation? Yes No Treatment? Yes No

Please list When: _____ By Whom: _____

Why is the patient seeking a consultation? _____

What is considered to be the primary problem? _____

What is the expected from orthodontic treatment? _____