Katie Evans Moffit, DDS, MSD
*Orthodontics for Children and Adults*
1460 Peterman Drive
Alexandria, LA 71301
(318) 473-4545

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 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? _____