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ORTHODONTICS

Member
American Association of
Orthodontists

PATIENT INFORMATION

Date_____

Patient's name_____ Nickname_____ Sex_____

Birthdate _____Age in years _____Occupation_____

Home address _____City/Zip_____ Phone _____

Business name and address of patient_____Phone _____

Name and address of person responsible for account_____ Phone _____

Social Security Number _____Drivers License Number_____

Spouse name _____ Occupation_____

Is patient covered by orthodontic insurance?_____If yes, please name _____

Family physician_____Family dentist_____

Referred by_____

Has patient had previous orthodontic treatment or consultation _____

Do you anticipate a move or transfer in the near future_____

MEDICAL INFORMATION - Check any of the following which apply

❑ Asthma ❑ Blood disease ❑ Diabetes ❑ Rheumatic fever ❑ Hepatitis ❑ Frequent colds

❑ Heart murmur ❑ Endocrine disorders ❑ "Fever blisters" ❑ A.I.D.S. ❑ Freq. headaches

Drugs or medication now taking/reasons_____

Drugs or allergy sensitivity_____

Is patient required to take antibiotics prior to dental treatment: ❑ Yes ❑ No

Injuries to face, head or teeth_____

Date of last dental visit _____Has the dentist removed any teeth_____

Jaw joint problems_____ Do you grind your teeth_____

Women: Are you pregnant? ❑ Yes ❑ No

CHIEF COMPLAINT: What is/are your reasons for being here?_____

_____

What would you like orthodontic treatment to accomplish?_____

_____

COMMENTS: _____

_____

*All patients must have teeth cleaned and be free from decay before orthodontic treatment can commence. Adults must also have a periodontal evaluation completed.