20mile ORTHODONTICS P.C.

1 PATIENT INFORMATION

Date: ____________

Patient's Name: ____________ Last ____________ First ____________ Middle

Address: ____________ Street ____________ City ____________ State ____________ Zip

Home Phone: ____________ Birthdate: ____________ Age: ______ Social Security #: ____________

General Dentist: ____________

How did you hear of our office: ____________

2 RESPONSIBLE PARTY INFORMATION

Name: ____________ Last ____________ First ____________ Middle ____________ Marital Status

Residence: ____________ Street ____________ City ____________ State ____________ Zip

Mailing Address: ____________ Street ____________ City ____________ State ____________ Zip

How Long at this address: ____________ Home Phone: ____________ Work Phone: ____________

Previous address *(if less than 3 years)* ____________ Street ____________ City ____________ State ____________ Zip

Social Security #: ____________ Birthdate: ____________ Relationship to Patient: ____________

Employer: ____________ Occupation: ____________ No. Years Employed: ____________

Spouse's Name: ____________ Last ____________ First ____________ Middle Relationship to Patient: ____________

Employer: ____________ Occupation: ____________ No. Years Employed: ____________

Social Security #: ____________ Birthdate: ____________ Work Phone: ____________

3 INSURANCE INFORMATION

Insured's Name: ____________ Insured's Soc. Sec. #: ____________

Insurance Co.: ____________ Group No.: ____________ Telephone #: ____________

Insurance Co. Address: ____________ Street ____________ City ____________ State ____________ Zip

Insured's Employer: ____________

Do you have dual coverage: Yes No If yes:

Insured's Name: ____________ Insured's Soc. Sec. #: ____________

Insurance Co.: ____________ Group No.: ____________ Local No.: ____________

Insurance Co. Address: ____________ Street ____________ City ____________ State ____________ Zip

Insured's Employer: ____________

4 EMERGENCY INFORMATION

Name of nearest relative not living with you: ____________

Complete Address: ____________

Phone: ____________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) : ____________ Date: ____________

Updates (dates/initial): ____________

(Over)
Please complete information on other side

5 MEDICAL HISTORY

Do you have a personal physician ❒ Yes ❒ No

Physician's Name: ______

Phone #: ______ Date of last visit: ______

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

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

Please explain: ______

Are you taking any prescription / over-the-counter drugs? ❒ Yes ❒ No

Please list each one: ______

For Women: Are you taking birth control pills? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week # ______

Are you nursing? ❒ Yes ❒ No

Have you ever had any of the following diseases or medical problems?

Y	N	Anemia / Radiation Treatment	Y	N	Heart Surgery / Pacemaker
Y	N	Artificial Bones / Joints	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Artificial Valves	Y	N	Hepatitis
Y	N	Asthma / Arthritis	Y	N	High / Low Blood Pressure
Y	N	Blood Transfusion	Y	N	HIV+ / AIDS
Y	N	Cancer / Chemotherapy	Y	N	Hospitalized for Any Reason
Y	N	Congenital Heart Defect	Y	N	Kidney Problems
Y	N	Diabetes / Tuberculosis (TB)	Y	N	Mitral Valve Prolapse
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Drug / Alcohol Abuse	Y	N	Rheumatic / Scarlet Fever
Y	N	Emphysema / Glaucoma	Y	N	Severe / Frequent Headaches
Y	N	Epilepsy / Seizures / Fainting Spells	Y	N	Shingles
Y	N	Fever Blisters / Herpes	Y	N	Sinus Problems
Y	N	Heart Attack / Stroke	Y	N	Ulcer / Colitis
Y	N	Heart Murmur	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: ______

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Latex
Y	N	Any Metal / Plastic	Y	N	Penicillin
Y	N	Codeine	Y	N	Tetracycline
Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin			

Please list any other drugs that you are allergic to: ______

6 DENTAL HISTORY

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

______

Have you ever had or been evaluated for orthodontic treatment? ❒ Yes ❒ No

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

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❒ Yes ❒ No

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

Do you like your smile? ❒ Yes ❒ No

Do your gums ever bleed? ❒ Yes ❒ No

Have you ever had an injury to your? ❒ Mouth ❒ Teeth ❒ Chin

Do you have any speech problems? ______

Do you generally breathe through your mouth? ❒ Y ❒ N Awake?

(Please check one) ❒ Y ❒ N Asleep?

Do you have any missing or extra permanent teeth? ❒ Yes ❒ No

Comments: ______