

**PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE**

|  |  |  |
| --- | --- | --- |
| Patient’s Name: Last | First | Middle In. |
| Address: Street | City | State | Zip |
| Birthdate (MM/DD/YYYY) | SSN |  |
| School | Sports/Hobbies |
|  |
| **RESPONSIBLE PARTY INFORMATION** |
| Name: Last | First | Middle In. |
| Residence: Street | City | State | Zip |
| How long at this address? | Home Phone | Cell Phone | Work Phone |
| Mailing Address: Street | City | State | Zip |
| Employer | Occupation | No. Years Employed |
| Relationship to Patient: | Birthdate (MM/DD/YYYY) | SSN |
|  |
| Name: Last | First | Middle In. |
| Relationship to Patient | Birthdate (MM/DD/YYYY) | SSN |
| Residence: Street |  City |  State ZIp  |
|

|  |  |  |  |
| --- | --- | --- | --- |
| How long at this address? | Home Phone | Cell Phone | Work Phone |

*How did you hear about our office?* |

**DENTAL INSURANCE INFORMATION**

|  |  |
| --- | --- |
| Insurance Company | Subscriber’s Name  |
| Subscriber’s ID No. | Subscriber’s Group No. | Subscriber’s Local No. |
| Insurance Co. Address | Ins. Co. Phone No. |
| ***Does the patient have dual coverage?*** *(Circle)* **NO YES** | *If yes, please fill out the below:* |
| Insurance Company | Subscriber’s Name (If Different than Above) |
| Subscriber’s ID No. | Subscriber’s Group No. | Subscriber’s Local No. |
| Insurance Co. Address | Ins. Co. Phone No. |

**EMERGENCY INFORMATION**

|  |  |
| --- | --- |
| Emergency Contact Name | Phone No. |
| Address: Street | City | State | Zip |

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Physician | Date of Last Visit | Phone No. |
| Address: Street | City | State | Zip |
| **Please Circle YES or NO**  | *If YES, please fill in details* |
| Is the patient taking any medication? | NO | YES |  |
| Is the patient allergic to any medication? | NO | YES |  |
| Does the patient have a history of a major illness? | NO | YES |  |
| Has the patient had any operations? | NO | YES |  |
| Has the patient been involved in a serious accident? | NO | YES |  |
| Have you seen a physician in the last 12 months? | NO | YES |  |
| Is the patient allergic to latex? | NO | YES |  |
| Is the patient allergic to any metals? | NO | YES |  |
| ***Female Patients Only*** |
| Has menstruation started? | NO | YES |  |
| Is the patient pregnant? | NO | YES |  |
| **Circle any of the medical conditions below which you have had or currently have**: |
| Abnormal Bleeding | Hemophilia | Diabetes | Hepatitis | Asthma |
| Prolonged Bleeding | Anemia | Arthritis | Dizziness | Pneumonia |
| Herpes | High Blood Pressure | Epilepsy | Hearing Impaired | Hayfever |
| Radiation/Chemotherapy | Tumor or Cancer | Heart Murmur | Rheumatic Fever | Tuberculosis |
| HIV/AIDS | Heart Problems | Liver Problems | Kidney Problems | Bone Disorders |
| Nervous Disorders | Congenital Heart Defect | Gastrointestinal Disorders |  |
| ***Are there any medical conditions not listed of which you feel we should be aware?*** |
|  |

**DENTAL HISTORY**

|  |  |  |
| --- | --- | --- |
| General Dentist | Date of Last Visit | Phone No. |
| Address: Street | City | State | Zip |
| *What is the main concern with the patient’s teeth?* |
| **Please Circle YES or NO**  | *If YES, please fill in details* |
| Is the patient presently in any dental pain? | NO | YES |  |
| Has the patient ever lost or chipped any teeth? | NO | YES |  |
| Have there ever been any injuries to face, mouth, or teeth? | NO | YES |  |
| Is the patient’s mouth sensitive to temperature/pressure? | NO | YES | Where? |
| Do the patient’s gums bleed when brushing? | NO | YES |  |
| Does the patient have any type of thumb or tongue habit? | NO | YES |  |
| Is the patient a mouth breather? | NO | YES |  |
| Has the patient ever seen an orthodontist? | NO | YES | Who and when? |
| What is the patient’s attitude toward receiving orthodontic treatment? |  |
| Has anyone in the family received orthodontic treatment? | NO | YES |  |
| Do the patient’s teeth or jaws ever feel uncomfortable first thing in the morning? | NO | YES |  |
| Does the patient experience jaw clicking or popping? | NO | YES |  |
| Does the patient clench or grind his/her teeth during the day? | NO | YES |  |
| Has the patient ever experienced chronic ringing in the ears? | NO | YES |  |
| Are you aware that some appointments will be during school hours? | NO | YES |  |

**BENEFITS**

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Hughes** to perform a complete orthodontic evaluation.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Dr.’s Initials\_\_\_\_\_\_\_