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align orthodontics

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Today's date _____

Patient's Name _____ _____ _____ _____ _____ _____ _____
First Middle Last I prefer to be called Sex Date of Birth Age

Patient's address _____ _____ _____
Street City Zip Code Home Phone Cell Phone

Father's Name _____ Mother's Name _____

Responsible Party Name _____ Responsible Party Address _____

Father's employer _____ Phone _____ Mother's employer _____ Phone _____

Family Dentist _____ Address _____ Phone _____

Who suggested your child might need orthodontic treatment? _____

How did you hear about our office? Internet? __ Insurance?__ Referral? __ If so, whom? _____ Other? __ (Please check one)

Attends school at _____ Number of brothers/sisters _____ Ages _____

Other family members treated here: _____

Hobbies _____ Sports _____ Other interests _____

Would you like to receive text messages for appointment reminders? If so, please list up to 3 cell phone numbers to receive text messages:

_____

INSURANCE

Is there insurance covering orthodontics?_____ Name of insurance carrier _____

Phone # and address of insurance carrier_____

Employer_____ Group # _____ Employee Name _____

Employee ID #_____ Employee Date of Birth _____

MEDICAL HISTORY

Patient size: _____ Average _____ Large _____ Small Patient's Height _____ Weight _____ Onset of puberty _____Yes _____No

Father's Height _____ Mother's Height _____ Natural Child _____ Adopted _____

Patient most resembles? _____ Mother _____ Father _____ Other

Present state of health: _____ Excellent _____ Good _____ Fair _____ Poor

Currently under physician's care? _____ Yes _____ No Why? _____

Is the patient under psychological guidance? _____ Yes _____ No

Currently taking medication? _____ Yes _____ No What? _____

Is there any history of:

_____ Speech problems _____ Bleeding disorders _____ Birth defects
_____ Facial injuries _____ Facial operations _____ Vision impairment
_____ Hearing problems _____ Tonsillitis _____ Asthma, sinus trouble, hay fever
_____ Bone fractures/major accidents _____ Rheumatoid or arthritic conditions _____ Cancer, tumor, radiation, or chemotherapy
_____ Frequent headaches, colds, or sore throats _____ Tonsil or Adenoid conditions
_____ Cardiovascular problem (heart murmur, rheumatic heart disease, congenital heart defects, etc.)

Please explain any of the above positive responses: _____

Allergies or reactions to the following:

____ Local anesthetics (novocaine or lidocaine) _____ Aspirin _____ Ibuprofen (Advil, Motrin)
____ Penicillin or other antibiotics _____ Latex (gloves, balloons) _____ Vinyl
____ Metals (jewelry, clothing snaps) _____ Acrylic _____ Other substances (specify)

Other Allergies? – Please list: _____

Serious illness? Operations? _____

DENTAL HISTORY

Has patient had: _____Regular dental check-ups _____ X-rays _____ Impressions ____ Extractions

Eruption of teeth: _____Early _____ Average _____ Late _____ Markedly delayed

Oral hygiene habits: _____ Good _____ Poor Intake of sweets: _____ High _____Moderate _____ Low

Indicate habits, past or present, relating to the mouth or face:

_____ Thumb or finger sucking - ____ Age? _____ Mouth breathing _____ Lip Biting
_____ Tongue thrust/swallowing problems _____ Chewing habits _____ Nail biting
_____ Sleeping habits _____ Tooth grinding/clenching _____ Speech problems

DENTAL and ORTHODONTIC INFORMATION

Now or in the past, has the patient had:

_____ Trouble losing baby teeth _____ Permanent or "extra" teeth removed ____ Extra or missing teeth
_____ Injury to baby or permanent teeth _____ Teeth sensitive to hot, cold/toothache ____ Jaw fractures/cysts/infections
_____ Root canals or "dead" teeth _____ Periodontal "gum problems" ____ Ringing in ears
_____ Pain/soreness in muscles of face _____ Difficulty chewing or opening jaw ____ Jaw pain
_____ Jaw clicking/popping/locking _____ Teeth irritating cheek, lip, tongue, or palate ____ Frequent cold sores
_____ Any relative with similar tooth or jaw relationships _____Concerned about spaced, crooked, or protruding teeth
_____ Ever had a prior orthodontic exam or treatment _____ Aware or concerned about under or over-developed jaw

Previous orthodontic treatment – Patient? _____ Yes _____ No Others in family? _____Yes _____ No

If so, with what result? ____Excellent _____Good _____ Poor

What do you consider to be the main benefits of orthodontic correction?

_____Cosmetic _____Functional _____ Psychological/ Emotional. Other _____

Is patient self-conscious of his/her teeth? _____ Yes _____ No

What is the patient's attitude toward treatment? _____Enthusiastic _____ Indifferent _____ Resentful

Expected patient cooperation: _____Excellent _____ Good _____ Fair _____ Poor

What is your primary concern? Why are you here?

_____

Is there any hereditary background which might contribute to this orthodontic problem?

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his /her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed _____ Date signed _____
(Parent or Guardian)

Signed _____ Date signed _____
(Witness)