Patient Information

Date:_______________

Patient's Name:____

Address: ____

Primary Phone Number:__________________________ **Birth Date**: ______________

E-Mail Address: ____

If patient is a minor, give parent's or guardian's name: _________________________

Whom may we thank for referring you to our office? ___________________________

Dentist: ____ **Date of Last Visit:** _________

Responsible Party Information

Name: ____

Mailing Address: ____

Primary Phone: ________________ **Work Phone**: ________________

Social Security #: __________________ **Birth Date**: _________________ **Relationship to Patient**: ____________________

Employer: _____________________________ **Occupation**: __________________________ **No. years employed**: ________

Spouse's Name: _____________________________________ **Relationship to Patient**: _____________________________

Employer: _____________________________ **Occupation**: __________________________ **No. years employed**: ________

Social Security #: _____________ **Birth Date**: _____________ **Work Phone**: ______________ **Cell Phone**: ______________

Dental Insurance Information

Insured's Name: ____ **Insured's Social Security #**: __________________

Insurance Company: _____________________________ **Group ID**: ________________ **Member ID**: __________________

Insurance Company Address: ____ **Phone No.**: ___________________

Do you have dual dental coverage? Yes_____ No_____ If YES:

Insured's Name: ____ **Insured's Social Security #**:______________

Insurance Company: _______________________________ **Group ID**:_________________ **Member ID**: _______________

Insurance Co. Address: ____ **Phone No.**: _________________________

Emergency Information

Name of nearest relative not living with you: ____

Complete address: ____

Phone: ____

Medical History

Please circle YES or NO (IF YES, please fill in details)

Yes No Are you taking any medications? ______________________________

Yes No Are you allergic to any medication? ______________________________

Yes No Do you have a history of major illness? ______________________________

Yes No Have you had any major operations? ______________________________

Yes No Have you ever been involved in a serious accident? ______________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Autism	Dental Anxiety	Diabetes
Anemia	Dizziness	Herpes	Pneumonia
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorder	HIV / AIDS	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney Problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Tumor or Cancer	Hepatitis/Liver problems

Are there any other medical conditions that you feel we should be aware of? ______________________________

Name of Physician______________________________

Dental History

What concerns you most about your teeth? ______________________________

Yes No Are you presently in any dental pain? ______________________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________________________

Yes No Have you ever lost or chipped any teeth? ______________________________

Yes No Have there been any injuries to your face, mouth or teeth? ______________________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ______________________________

Yes No Do your gums bleed when you brush? ______________________________

Yes No Do you have any type of thumb or tongue habit? ______________________________

Yes No Can you always breathe through your nose? ______________________________

Yes No Have you ever seen an orthodontist and received orthodontic treatment? ______________________________

What is your attitude toward receiving orthodontic treatment? ______________________________

Yes No Has anyone in your family received orthodontic treatment? ______________________________

How did they feel about the result? ______________________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________________

Yes No Are you aware of your jaw clicking or popping? ______________________________

Yes No Are you aware of clenching your teeth during the day? ______________________________

Yes No Have you ever been told that you grind your teeth? ______________________________

Yes No Do you have “tension” headaches or migraines ? ______________________________

Yes No Have you ever experienced chronic ringing in your ears? ______________________________

If the patient is under 16, height of parents? Mom______________________________ Dad______________________________

Yes No Are you aware that some appointments will be during school/work hours?

Please list some hobbies or interests: ______________________________

Female Patients Only:

Yes No Are you pregnant?

Yes No Has menstruation started?

Consent

Benefits of Orthodontists: 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 may be used for educational 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. Thomas M. Burns, D.M.D. to perform a complete orthodontic evaluation.

Signature: ______________________________ **Date:** ______________________________