Orthodontic AVENUE

PATIENT INFORMATION

Patient's Full Name: _____

Nickname: _____ Date of Birth: _____

Mailing Address: _____

City: State: Zip Code:

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____ Social Security: _____-_____-_____

Who is your dentist: _____

Preferred method of contact? ☐ TEXT ☐ E-MAIL ☐ CALL

Who referred you to our office?: _____

RESPONISBLE PARTY INFORMATION

Responsible Party's Full Name: _____

Date of Birth: _____ Social Security: _____-_____-_____

Home Phone Number: _____ Cell Phone Number: _____

Address (if different from patient):_____

City: State: Zip Code:

Email Address: _____

Relationship to Patient: _____ Would you like to get braces today?:_____

INSURANCE INFORMATION

Subscriber's Full Name: _____ Date of Birth: _____

Social Security: _____-_____-_____ Insurance Company: _____

Employer's Name: _____

Member ID: _____ Group Number: _____ Effective Date: _____

Relationship to Subscriber: _____

EMERGENCY INFORMATION

Emergency Contact Person: _____ Relationship to Patient: _____

Cell Phone Number: _____ Email Address: _____

MEDICAL HISTORY

PRIMARY PHYSICIAN: _____ DATE OF LAST VISIT: _____

PHYSICIAN'S OFFICE PHONE NUMBER: _____

PLEASE CIRCLE YES OR NO (IF YES, PLEASE FILL IN DETAILS):

YES NO IS THE PATIENT TAKING ANY MEDICATION? _____

YES NO IS THE PATIENT ALLERGIC TO ANY MEDICATION? _____

YES NO HAS THE PATIENT HAD ANY OPERATIONS? _____

YES NO IS THE PATIENT PREGNANT? _____

CIRCLE ANY OF THE MEDICAL CONDITIONS BELOW THAT THE PATIENT HAS HAD OR CURRENTLY HAS:

ABNORMAL BLEEDING/HEMOPHILIA	DIABETES	HEPATITIS/LIVER PROBLEMS	PNEUMONIA
ANEMIA	DIZZINESS	HERPES	PROLONGED BLEEDING
ARTHRITIS	EPILEPSY	HIGH BLOOD PRESSURE	RADIATION/CHEMOTHERAPY
ASTHMA	GASTROINTESTINAL DISORDERS	HIV/AIDS	RHEUMATIC FEVER
BONE DISORDERS	HEART PROBLEMS	KIDNEY PROBLEMS	TUBERCULOSIS
CONGENITAL HEART DEFECT	HEART MURMUR	ANXIETY DISORDERS	TUMOR OR CANCER

Are there any medical conditions we have not discussed that you feel we should be aware of?: _____

DENTAL HISTORY

General Dentist: _____ Date of Last Visit: _____

YES NO IS THE PATIENT PRESENTLY IN ANY DENTAL PAIN?

YES NO EVER EXPERIENCED ANY UNFAVORABLE REACTION TO DENTISTRY?

YES NO HAS THE PATIENT EVER LOST OR CHIPPED ANY TEETH?

YES NO HAVE THERE BEEN ANY INJURIES TO FACE, MOUTH, OR TEETH?

YES NO IS ANY PART OF YOUR MOUTH SENSITIVE TO TEMPERATURE? WHERE?: _____

YES NO IS ANY PART OF YOUR MOUTH SENSITIVE TO PRESSURE? WHERE?: _____

YES NO DO GUMS BLEED WHEN BRUSHING?

YES NO ANY TYPE OF THUMB OR TONGUE HABIT?

YES NO IS THE PATIENT A MOUTH BREATHER?

YES NO HAS THE PATIENT EVER SEEN AN ORTHODONTIST? WHO? WHEN?: _____

YES NO WHAT IS THE PATIENT'S ATTITUDE TOWARD RECEIVING ORTHODONTIC TREATMENT?: _____

YES NO DO YOUR TEETH OR JAWS EVER FEEL UNCOMFORTABLE FIRST THING IN THE MORNING?

YES NO EXPERIENCCE JAW CLICKING OR POPPING?

YES NO AWARE OF CLENCHING OR GRINDING TEETH DURING THE DAY?

YES NO EXPERIENCE "TENSION" HEADACHES?

YES NO DOES THE PATIENT NEED EXTRA HELP WITH INSTRUCTIONS?

YES NO IS THE PATIENT SENSITIVE OR SELF-CONCIOUS ABOUT HIS/HER TEETH?

YES NO ARE YOU AWARE THAT SOME APPOINTMENTS WILL BE DURING SCHOOL HOURS?

BENEFITS:

I certify this information is true and correct to the best of my knowledge. I understand that i am responsible for all financial charges:

Sign: _____ Date: _____