A B C

Patient Information

Patient's name____ Preferred Name ________________
Last First Middle

Address ____
Street City Zip

Home Phone____________________ Email ______________________ Birth date ____________ Age ______

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

What concerns you most about your teeth? ____

Please list some hobbies or interests ____

Responsible Party Information

Name____ Relationship to Patient ____________
Last First Middle

Address ____
Street City Zip

How long at this address?_____ Home phone______________________ Work phone ______________________

Previous Address (If less than 3 years) ____

Employer_________________________________ Occupation__________________ No. years employed _____

Birthdate____________ Email ______________________ Married / Single / Divorced (Please circle one)

Spouse's Name____Relationship to Patient ____________

Address if different than Patient ____

Employer______________________________Occupation__________________ No. years employed________

Birthdate ______________ Work Phone __________________ Email_________________________________

Dental Insurance Information

Insured's Name______________________________ Insured's SSN or ID # __________________________

Dental Insurance Company______________________ Group No.______________ Birth date____________

Insurance Co. Address____ Phone No. ________________

If you have dual dental insurance coverage, please enter the following information about the other plan:

Insured's Name______________________________Insured's SSN or ID # __________________________

Dental Insurance Company______________________ Group No.______________ Birth date____________

Insurance Co. Address____ Phone No. ________________

Emergency Information

Name of nearest relative not living with you ____

Complete address____
Street City Zip

Phone ____

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

Signature (Parent's signature if minor)_______________________________________Date _______________

MEDICAL HISTORY

Physician____ Date of Last Visit___________________________
Address____ Phone ___________________________________

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ____

Yes No Do you have any allergies? ____

Yes No Do you have a history of a 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.

Arthritis	Diabetes	Hepatitis/Liver problems	Metal Allergies
Artificial joints	Dizziness	Herpes	Nervous Disorders
Asthma or Hay-fever	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Blood or bleeding disorders	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Growth Disorders	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Problems or Murmur	Latex Allergy	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of or additional information you feel may be helpful? ____

DENTAL HISTORY

Dentist____ Date of last exam & cleaning ________________

Any restorative work remaining to be done? ____

Yes No Do you take antibiotics before your dental visits? ____

Yes No Are you presently in any dental pain? ____

Yes No Have there been any injuries to 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, tongue or lip habit? ____

Yes No Are you a mouth breather? ____

Yes No Have you ever seen an orthodontist? If yes, who and when? ____

Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _________

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

How did they feel about the result? ____

What is your attitude toward receiving orthodontic treatment? ____

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? ____

Yes No If the patient is under age 16, approximate height of parents? Mom______ Dad______

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

Female Patients only

Yes No Are you pregnant? ____

Yes No Has menstruation started? If so, when? (tells us about growth remaining)___________________

Orthodontics is a service that provides an improvement in the general function, health and appearance of the teeth. As with any treatment, some risks are involved. Teeth, gums and jaws are an intricate body part and may not respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening may occur in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and the jaws after treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my personal, medical or dental history. In addition, I authorize Bull Mountain Orthodontics, its doctors and staff to perform a complete orthodontic evaluation including radiographs (x-rays), photos and impressions (molds) of the patient’s teeth. <u>I have read and understand this paragraph; I also understand that my diagnostic records may be used for educational and promotional purposes.</u>

Signature (Parent’s signature if minor)____Date __________________