

PATIENT INFORMATION FORM

DATE _____

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP)

Birth Date: _____ Email Address of Parent: _____

Employer/School: _____ Occupation/Grade: _____

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____

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

Dentist's Name _____ Dentist's Phone: () _____
(First) (Last)

NOTE: *If you would like us to accurately determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any future treatment, insurance information must be filled out completely at the time of your initial examination.*

Do you have orthodontic insurance? No ___ Yes ___ Carrier: _____ Phone #: _____

Name of Primary Insured: _____ Primary's Employer: _____

Primary's Birth Date: _____ Primary's Social Security #: _____ Group/Plan No: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP)

Previous Address (if less than 3 years): _____

Relationship to Patient: _____

Employer: _____ Occupation: _____ No. of Years Employed: _____

Home Phone: () _____ Work Phone: () _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Occupation: _____ Spouse's Work Phone: () _____

If Patient is a minor parents are: ___ Married ___ Divorced ___ Separated ___ Single ___ Remarried ___ Widowed

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You: _____
(Last) (First)

Address: _____
(Street) (Apt. #)

(City) (State) (ZIP) Phone Relationship

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

NAME _____

DATE _____

I. SUBJECTIVE COMPLAINTS AND CONCERNS

A. What are the patient's or parents' main concerns regarding the jaw and teeth?

	Mild	Moderate	Severe
1. Facial Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Gum Disease/Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Gum Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Jaw Dysfunction.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Jaw Joint Sounds.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Jaw Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Neck Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ringing or "Stuff" Ears...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Bad Bite
- "Buck" Teeth/ Overjet
- Crowding of Upper Teeth
- Crowding of Lower Teeth
- Crowding of Upper and Lower Teeth
- Crossbite
- Dentist Recommended Seeing an Orthodontist
- Grinding Teeth
- Gummy Smile
- Impacted Tooth/ Teeth
- Improper Tooth Position
- Irregular Facial Proportions
- Irregular Shaped Tooth/ Teeth
- Missing Tooth/ Teeth
- Mouth Too Small
- Open Bite
- Overbite
- Prominent Lower Jaw (too 'strong')
- Protrusion of Teeth
- Recessive Lower Jaw (too 'weak')
- Rotations
- Small Teeth
- Spaces
- Thumb/ Finger Habit
- Underbite
- OTHER _____

B. Family members with similar problems:

- Patient Adopted
- Father
- Mother
- Brother
- Sister
- OTHER _____

II. MEDICAL DENTAL HISTORY

A. Present Health	Good	Fair	Poor
1. Physical.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Emotional.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stress Level.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Has the patient reached puberty? Yes No

C. Has the patient ever had any of the following conditions?

- Allergies
- Arteriosclerosis
- Asthma
- Autoimmune Disorder
- Blood Disease
- High Blood Pressure
- Low Blood Pressure
- Bone Disorders
- Cancer
- Diabetes
- Dizziness
- Emotional Problems
- Endocrine Problems
- Epilepsy
- Female Problems
- GERD (Acid Reflux)
- Hearing Disorders
- Heart Disease
- Hepatitis
- HIV/AIDS/ARC (Circle)
- Kidney Disease
- Latex Allergy
- Rheumatic Fever
- Ringing of Ears
- Sleep Disturbance (Sleep Apnea)
- Trauma (to face, teeth, jaws, or head)
- OTHER _____

D. MEDICATIONS – Current medications taken by the patient:

- Antibiotics
- Birth Control Pills
- Bisphosphonates (Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Zometa, etc.)
- Diet Pills (diuretics)
- Heart Pills (digitalis, etc.)
- Insulin
- Muscle Relaxants (valium, etc.)
- Pain Pills (demerol, codeine, etc.)
- Sleeping Pills
- Tranquilizers or Antidepressants (elavil, valium, etc.)
- Vitamins
- OTHER _____

E. ALLERGIES TO MEDICATIONS/FOOD – The patient demonstrates an allergic response to:

- Antibiotics (specifically) _____
- Dairy Products
- Food Dyes
- Pain Pills (specifically) _____
- Wheat
- OTHER _____

F. OTHER PERTINENT INFORMATION – Has the patient ever had a history of the following?

- | | | |
|-------------------------------|--------------------------|--------------------------|
| | Occasionally | Frequently |
| 1. Clicking in Jaw Joint..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Colds..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Difficulty Chewing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Difficulty Swallowing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Finger Sucking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Grinding Teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Lip Biting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Mouth Breathing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Pain in Jaw Joint..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Smoking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Snoring..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Sore Teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Sore Throats..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Speech Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Thumb Sucking..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Tongue Thrusting..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Tonsillitis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Other Habits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. OTHER _____ | <input type="checkbox"/> | <input type="checkbox"/> |

III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND OTHODONTIC TREATMENT

A. Regular dental checkups:

- Twice a year
- Once a year
- Only if necessary
- Never

B. Patient's interest in orthodontic treatment:

- Eager for treatment
- Willing if necessary
- Dreading but agrees
- Unwilling

C. Orthodontic consultation was prompted by:

- Patient (Name) _____
- Dentist (Name) _____
- Mother
- Father
- Spouse
- Brother
- Sister
- Other relative (Name) _____
- Friend (Name) _____
- OTHER _____

Yes No

D. Has the patient ever had any unusual dental experiences?.....

If yes, please explain: _____

Yes No

E. Are there any medical, dental, surgical, or psychological problems not covered above?

If yes, please explain: _____

Yes No

F. Has the patient ever had a previous orthodontic consultation or treatment?....

Name of the Dr. _____

G. Why are you seeking this consultation?

- To improve dental appearance
- To improve facial appearance
- To improve general appearance
- To improve longevity of teeth
- To improve self-esteem
- To reduce facial pain
- To reduce headaches/neckaches
- OTHER _____

G. Date of Last Dental Exam (mm/yy) _____

H. Siblings / Children (Children 18 and Under Only)

<i>Name</i>	<i>Age</i>
_____	_____
_____	_____
_____	_____

Comments:

To the best of my knowledge, all the preceding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

Patient/ Responsible Party's Signature

Date



Smiles from the Heart

Interdisciplinary Orofacial Examination for Children and Adolescents

Patient Personal Data:

Name: _____ Age: _____ Date: _____
 Gender: _____ Weight: _____ Height: _____

Parents Assessment:

- | | | | |
|---|---|---|------------|
| Does your child usually snore while sleeping? | Y | N | Don't know |
| Does your child have difficulty breathing or breathes with excess effort? | Y | N | Don't know |
| Have you noticed any of the following in your sleeping child? | | | |
| Break or pause in sleeping | Y | N | Don't know |
| Restless or agitated sleep | Y | N | Don't know |
| Occasional enuresis (bed wetting) | Y | N | Don't know |
| Frequent enuresis | Y | N | Don't know |
| Abnormal head posture | Y | N | Don't know |
| Excessive sweating | Y | N | Don't know |
| Does he/she wet the pillow with saliva/drool? | Y | N | Don't know |
| Does he/she get overly tired from playing? | Y | N | Don't know |
| Do they keep mouth open while watching TV? | Y | N | Don't know |
| Does he/she drool during the day? | Y | N | Don't know |
| Does he/she frequently catch a cold? | Y | N | Don't know |
| Does he/she have allergies? | Y | N | Don't know |
| Habits: | | | |
| Pacifier | Y | N | Don't know |
| Thumb sucking | Y | N | Don't know |
| Nail-biting | Y | N | Don't know |
| Other? | Y | N | Don't know |
| Does he/she frequently lose their voice? | Y | N | Don't know |
| Does he/she have pronunciation problems? | Y | N | Don't know |
| Is your child hard to wake up in the morning? | Y | N | Don't know |
| Does your child wake up with a headache in the morning? | Y | N | Don't know |
| Does your child have difficulty listening? | Y | N | Don't know |
| Is your child easily distracted? | Y | N | Don't know |
| Is your child overly active? | Y | N | Don't know |

5/2019