Patient Information

Today's date:____________________

Name: ____ *Male/Female* Date of Birth:________________ Age:____

Address: ____ City:___________State:___________Zip:____________

Home Phone:____ Work Phone:________________________________

Cell Phone (Responsible Party): _______________________ E-mail address (Resp. Party): _____________________

Preferred Method of Contact: __________________________ Are you on Facebook? Yes No

Whom may we thank for referring you?____

Have we seen any other family members?______Their names:____

Family Dentist? ____

Has patient ever seen another orthodontist?____

Biological Parents/Legal Guardians ***(Patients under age 18)***

Father's Name:_________________________________ Mother's Name:_________________________________

Soc. Sec. #:____________________________________ Soc. Sec. #:____________________________________

Date of birth: __________________________________ Date of birth: __________________________________

Marital Status:__________________________________ Marital Status:__________________________________

Height:____ Height:____

Employer: _____________________________________ Employer: _____________________________________

Occupation: ____________________________________ Occupation: ____________________________________

No. of years employed: __________________________ No. of years employed: __________________________

Address: _______________________________________ Address: _______________________________________

Previous Address:_______________________________ Previous Address:_______________________________

Home Phone:____________________________________ Home Phone:____________________________________

Cell Phone: _____________________________________ Cell Phone:_____________________________________

E-mail address: _________________________________ E-mail address:_________________________________

All legal guardians are financially responsible for the care of their child and this account

Insurance Information

Insured's Name: _________________________________ Insured's SS#: _______________ Birthdate: _______________

Relationship to Patient: ☐Mother ☐Father ☐Other: ________________ Insured's Employer: __________________

Insurance Co: ___________________________ Group #: _________________ Phone #: _________________________

Insurance Co. Address: ____

Do you have dual coverage? ☐ Yes ☐No If yes: ____

Insured's Name: _________________________________ Insured's SS#: _______________ Birthdate: _______________

Relationship to Patient: ☐Mother ☐Father ☐Other: ________________ Insured's Employer: __________________

Insurance Co: ___________________________ Group #: _________________ Phone #: _________________________

Insurance Co. Address: ____

I understand where appropriate, a credit report may be obtained. I also hereby authorize release of any information relating to this claim. And I also authorize payment of insurance benefits directly to E&S Orthodontics.

Signature: ____ Date: _____________________________________

Please notify our office of any changes in your insurance policy as soon as possible.

DENTAL HISTORY

Referred by____________________How would you rate the condition of your mouth? ▢ Excellent ▢ Good ▢ Fair ▢ Poor
Previous Dentist ________________________________How long have you been a patient?________Months/Years
Date of most recent dental exam ______/______/______ Date of most recent x-rays ______/______/______
Date of most recent treatment (other than a cleaning) ______/______/______
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) ______________________________
2. Have you had an unfavorable dental experience? ______________________________
3. Have you ever had complications from past dental treatment? ______________________________
4. Have you ever had trouble getting numb or reactions to local anesthetic?______________________________
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______________________________
6. Have you had any teeth removed?______________________________

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change?______________________________
8. Have you ever whitened (bleached) your teeth? ______________________________
9. Are you self conscious about your teeth? ______________________________
10 Have you been disappointed with the appearance of previous dental work? ______________________________

BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum? ______________________________
12. Do you / would you have any problems chewing bagels or other hard foods?______________________________
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______________________________
14. Are your teeth crowding or developing spaces? ______________________________
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? ______________________________
16. Do you have any problems with sleep or wake up with an awareness of your teeth? ______________________________
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______________________________
18. Do you have tension headaches or sore teeth? ______________________________
19. Do you wear or have you ever worn a bite appliance? ______________________________

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years?______________________________
21. Do you have a dry mouth? ______________________________
22. Are any teeth sensitive to hot, cold, biting or sweets?______________________________
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? ______________________________
24. Do you avoid brushing any part of your mouth?______________________________
25. Do you feel or notice any holes (i.e. pitting) in your teeth? ______________________________

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease?______________________________
27. Have you ever experienced gum recession?______________________________
28. Is there anyone with a history of periodontal disease in your family? ______________________________
29. Do your gums bleed when brushing, flossing or eating?______________________________
30. Are your teeth becoming loose?______________________________
31. Have you ever noticed an unpleasant taste or odor in your mouth? ______________________________
32. Have you experienced a burning sensation in your mouth?______________________________

Patient's Signature ____ Date ______________

Doctor's Signature ____ Date ______________

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MEDICAL HISTORY

Patient Name ______________________________ Nickname ______________ Age ________
Name of Physician/and their specialty ______________________________
Most recent physical examination ______________________ Purpose ______________________
What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: YES NO

1. hospitalization for illness or injury ____________
2. an allergic reaction to
   - aspirin, ibuprofen, acetaminophen
   - penicillin
   - erythromycin
   - tetracycline
   - codeine
   - local anesthetic
   - fluoride
   - metals (gold, stainless steel)
   - latex
   - any other medications ____________
3. heart problems ____________
4. heart murmur ____________
5. rheumatic fever ____________
6. scarlet fever ____________
7. high blood pressure ____________
8. low blood pressure ____________
9. a stroke ____________
10. artificial prosthesis (i.e. heart valve or joints) ____________
11. anemia or other blood disorder ____________
12. prolonged bleeding due to a slight cut ____________
13. emphysema ____________
14. tuberculosis ____________
15. asthma ____________
16. breathing or sleep problems (i.e. snoring, sinus) ____________
17. kidney disease ____________
18. liver disease ____________
19. jaundice ____________
20. thyroid or parathyroid disease ____________
21. hormone deficiency ____________
22. high cholesterol ____________
23. diabetes ____________
24. stomach or duodenal ulcer ____________
25. digestive disorders (i.e. gastric reflux) ____________

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __
27. arthritis ____________
28. glaucoma ____________
29. contact lenses ____________
30. head or neck injuries ____________
31. epilepsy, convulsions (seizures) ____________
32. neurologic problems ____________
33. viral infections and cold sores ____________
34. any lumps or swelling in the mouth ____________
35. hives, skin rash, hay fever ____________
36. venereal disease ____________
37. hepatitis (type ___) ____________
38. HIV / AIDS ____________
39. tumor, abnormal growth ____________
40. radiation therapy ____________
41. chemotherapy ____________
42. emotional problems ____________
43. psychiatric treatment ____________
44. antidepressant medication ____________
45. alcohol / drug dependency ____________

ARE YOU:

46. presently being treated for any other illness ____________
47. aware of a change in your general health ____________
48. taking medication for weight management (i.e. fen-phen)
49. taking dietary supplements ____________
50. often exhausted or fatigued ____________
51. subject to frequent headaches ____________
52. a smoker or smoked previously ____________
53. considered a touchy person ____________
54. often unhappy or depressed ____________
55. FEMALE - taking birth control pills ____________
56. FEMALE - pregnant ____________
57. MALE - prostate disorders ____________

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________________ Date ____________

Doctor's Signature ______________________________ Date ____________

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