PATIENT INFORMATION FORM

PATIENT INFORMATION

Name: ______________________________ Gender: ________

Address: ______________________________ City: ________ State: ____ Zip: ________

Birthdate: ______________ Age: _______ SS #: ______________ Occupation: ______________

Employer: ______________________________ # of Years Employed: ______________

Work #: ______________ Home #: ______________ Cell #: ______________

E-Mail Address: ______________________________

Hobbies/Sports: ______________________________

School: ______________________________ City of School: ______________

Other family members seen by us (provide age): ______________________________

Sibling(s) not listed above (current or treated elsewhere): ______________________________

Whom may we THANK for referring you to our office? ______________________________

Dentist's Name: ______________ City: ______________ Ph #: ______________ Last Visit : ________

Responsible Party's Signature: ______________________________ **Today's Date:** ______________

INSURANCE INFORMATION

INSURANCE: 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 **BEFORE** you come in for your initial appointment. (Note: Orthodontics is Dental and TMJ is Medical)

Do you have Orthodontic Insurance? ____ No ___ Yes Carrier: ______________ Member ID #: ______________

Carrier Address: ______________________________ Carrier Ph #: ______________

Name of Primary Insured: ______________ Primary Birthdate: ________ Primary SS#: ______________

Do you have Secondary Insurance? ____ No ___ Yes Carrier: ______________ Member ID #: ______________

Carrier Address: ______________________________ Carrier Ph #: ______________

Name of Secondary Insured: ______________ Secondary Birthdate: ________ Secondary SS#: ______________

RESPONSIBLE PARTY INFORMATION

NOTE: If separated/divorced the responsible party of the child is the custodial parent. The person responsible for account and signing contract is the ***only person*** legally able to acquire information regarding patient. If responsible party has legal custody of a person under 18 and the relationship to the person is not mother/father, please provide information below.

Name: ______________________________ Relationship to Patient: ______________

Employer: ______________________________ Occupation: ______________ # of Years Employed: ______________

Home #: ______________ Cell #: ______________ SS#: ______________ Birthdate: ______________

Billing Address: ______________________________

Previous Address (if less than 3 years): ______________________________

Mother's Information: ☐Step Mother ☐Guardian Name: ______________ Birthdate: ______________

SS#: ______________ Home #: ______________ Cell #: ______________

Father's Information: ☐Step Father ☐Guardian Name: ______________ Birthdate: ______________

SS#: ______________ Home #: ______________ Cell #: ______________

Who is Reponsible for Making Appointments? Name: ______________________________

Relationship to Patient: ______________ Home #: ______________ Cell #: ______________

If you are **NOT** the *Patient* or the *Responsible Party* filling out this form, please provide:

Name: ______________________________ Relationship to Patient: ______________

Address: ______________________________ Home #: ______________ Cell #: ______________

Signature: ______________________________ **Today's Date:** ______________

EMERGENCY INFORMATION

Primary Physician's Name: ______________________________ Phone #: ______________

Physician's Address: ______________________________ City: ______________

Name of nearest relative NOT living with you: ______________________________

Address: ______________________________

Home #: ______________ Work #: ______________ Cell #: ______________

Advanced Family Dental & Orthodontics

ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

DATE: ________________________________

NAME: ________________________________

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	☐	☐	☐
2. Gum Disease/Recession	☐	☐	☐
3. Gum Problems	☐	☐	☐
4. Headaches	☐	☐	☐
5. Jaw Dysfunction	☐	☐	☐
6. Jaw Joint Sounds	☐	☐	☐
7. Jaw Pain	☐	☐	☐
8. Neck Pain	☐	☐	☐
9. Ringing or "Stuffy" Ears	☐	☐	☐

- ☐ 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 Shaped Tooth / Teeth
- ☐ Missing Tooth / Teeth
- ☐ Mouth Too Small
- ☐ Open Bite
- ☐ Prominent Low 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:

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ OTHER ________________________________

II. MEDICAL DENTAL HISTORY

A. Present Health

	Good	Fair	Poor
1. Physical	☐	☐	☐
2. Emotional	☐	☐	☐
3. Under Stress	☐	☐	☐

	Yes	No
B. Has the patient reached puberty?	☐	☐

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

- ☐ Allergies
- ☐ AIDS / ARC / HIV (Circle)
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Emotional Problems
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Female Problems
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Hearing Disorders
- ☐ Heart Disease / Surgery
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure / Low Blood Pressure (Circle)
- ☐ Hospitalized for Any Reason
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Disturbance
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Trauma (to face, teeth, jaws or head)
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ ________________________________

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D. **MEDICATIONS** *(Current medications taken by patient):*

- ☐ Antibiotics
- ☐ Birth Control Pills
- ☐ Diet Pills (Diuretics)
- ☐ Heart Pills (Digitalis, etc.)
- ☐ Insulin
- ☐ Muscle Relaxants (Valium, etc.)
- ☐ Pain Pills (Demerol, Codeine, etc.)
- ☐ Sleeping Pills
- ☐ Tranquilizers (Elavil, Valium, etc.)
- ☐ Vitamins
- ☐ OTHER ______________________________

E. ALLERGIES TO MEDICATIONS/FOOD *(The patient demonstrates an allergic response to):*

- ☐ Antibiotics (specifically) ____________________
- ☐ Aspirin
- ☐ Codeine
- ☐ Dairy Products
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food Dyes
- ☐ Jewelry / Metals
- ☐ Latex
- ☐ Pain Pills (specifically) ____________________
- ☐ Wheat
- ☐ OTHER ______________________________

F. OTHER PERTINENT INFORMATION *(Has the patient ever had a history of the following?):*

	Occasionally	Frequently
1. Other Habits	☐	☐
2. Colds	☐	☐
3. Difficulty Chewing	☐	☐
4. Difficulty Swallowing	☐	☐
5. Finger Sucking	☐	☐
6. Grinding Teeth	☐	☐
7. Headaches	☐	☐
8. Lip Biting	☐	☐
9. Mouth Breathing	☐	☐
10. Pain in Jaw Joint	☐	☐
11. Smoking	☐	☐
12. Snoring	☐	☐
13. Sore Teeth	☐	☐
14. Sore Throats	☐	☐
15. Speech Problems	☐	☐
16. Thumb Sucking	☐	☐
17. Tongue Thrusting	☐	☐
18. Tonsillitis	☐	☐
19. Other Habits	☐	☐
20. OTHER________________	☐	☐

III. PATIENTS OR PARENTS ATTITUDE TOWARD TEETH CARE AND ORTHODONTIC 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) ________________________
- ☐ Spouse
- ☐ Mother / Father (Circle)
- ☐ Brother / Sister (Circle)
- ☐ Other relative (Name) ____________________
- ☐ Friend (Name) ________________________
- ☐ OTHER ______________________________

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

- ☐ No
- ☐ Yes If yes, please explain: ________________

____

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

- ☐ No
- ☐ Yes If yes, please explain: ________________

____

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

- ☐ No
- ☐ Yes If yes, Name of Doctor: ________________

G. HEALTH PROFESSIONAL(S) *(Current or have seen previously)*

Doctor Name: ______________________________
Reason(s) for treatment: ________________________

Doctor Name: ______________________________
Reason(s) for treatment: ________________________

Doctor Name: ______________________________
Reason(s) for treatment: ________________________

H. 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 ______________________________

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

____
Orthodontist/General Dentist's Signature Date

Date	Comments	

PROFILE
115 convax
116 concave
117 straight

MANDIBLE
118 mesognathic
119 retrognathic
120 prognathic

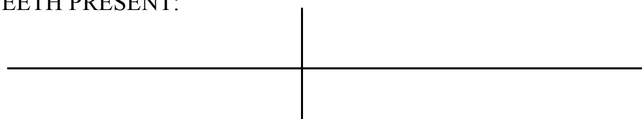
SYMMETRY
000 symmetrical
039 mandibles to RT
039 mandibles to LT
other ________

LIPS AT REST
058 together
059 apart
060 trapped

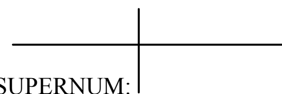
FACIAL HEIGHT
121 normal
122 short
123 long

DENTAL LEVEL
000 primary
000 mixed
000 permanent

TEETH PRESENT:



TEETH MISSING:



MOLAR CLASS
001 Class I
002 Class II div 1 RL
003 Class II div 2 RL
004 Class III

CROWDING
007 none upper
008 none lower
015 upper sl mod sev
016 lower sl mod sev

SPACING
005 upper
019 diasiama
005 lower

MAX MIDLINE
000 normal
040 to RT
041 to LT

SUPERNUM:

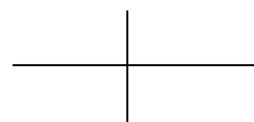
OVERBITE
025 mod 25-75%
022 deep 75-100%
021 100% +
024 openbite
027 edge-edge

OVERJET
036 mod 1-3 mm
037 excess 4-6 mm
038 severe 7+
039 end-end

CROSSBITE
025 anterior

028 posterior

029 max buccal



MAND MIDLINE
000 normal
042 to RT
043 to LT

ENAMEL DEFECTS
096 decalcifications
097 defects
098 attrition
379 abiraction

TMJ SYMPTOMS
051 none R,L
380 negload test
052 click/pop R, L
opening, closing, lateral
055 crepitus R, L
056 condylar pain R, L
057 muscle pain

MANDIBULAR MOVEMENT
051 no deviation
053 opening deviation R, L
054 closing deviation R, L

RANGE OF OPENING
110 normal _____ mm
111 limited _____ mm

PERIO
084 healthy
085 gingivitis
087 recession
086 periodontis

COMMENTS: ____