

**PATIENT INFORMATION FORM**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Cell \_\_\_\_\_ Other Phone # \_\_\_\_\_ Email \_\_\_\_\_

Referred By \_\_\_\_\_ Dentist \_\_\_\_\_ Physician \_\_\_\_\_

Date of last Dental Exam \_\_\_\_\_

Patient's Occupation (if applicable) \_\_\_\_\_ Business Name: \_\_\_\_\_

Patient's interests & Hobbies \_\_\_\_\_

Sports \_\_\_\_\_ Musical Instruments \_\_\_\_\_

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***If patient is 18 years of age or under please complete this section, otherwise please continue to the next section.***

Father's Name \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Father's Occupation \_\_\_\_\_ Business Name \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Mother's Occupation \_\_\_\_\_ Business Name \_\_\_\_\_

Parent(s) Marital Status: Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

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**ORTHODONTICS INFO**

Reason for Orthodontic Consultation \_\_\_\_\_

Has anyone in family had a similar problem?  
\_\_\_\_\_

Has anyone in the Family had orthodontic treatment? Yes | No If Yes, please enter information below:

Names \_\_\_\_\_ Date Treated? \_\_\_\_\_ Orthodontist \_\_\_\_\_

Names \_\_\_\_\_ Date Treated? \_\_\_\_\_ Orthodontist \_\_\_\_\_

Patient's attitude toward orthodontics \_\_\_\_\_

Is patient self-conscious about their teeth? \_\_\_\_\_

***Please continue on the other side***

MEDICAL & DENTAL HISTORY

Is patient in good health? \_\_\_\_\_ Date of last medical exam \_\_\_\_\_  
 Is patient under physicians care? \_\_\_\_\_ If yes, please indicate as to why \_\_\_\_\_  
 Medication(s) taking \_\_\_\_\_  
 List any allergies or drug sensitivities \_\_\_\_\_  
 Have tonsils or adenoids been removed? \_\_\_\_\_

Check the following where applicable to the patient

- |                         |                        |                         |
|-------------------------|------------------------|-------------------------|
| ____ Asthma             | ____ Hepatitis         | ____ Vision impairment  |
| ____ Diabetes           | ____ Heart Problems    | ____ X-ray therapy      |
| ____ Epilepsy           | ____ Hearing disorders | ____ Emotional problems |
| ____ Bleeding disorders |                        |                         |

Please list any other illness/issues/accidents and or hospitalizations \_\_\_\_\_

Check any that apply	Which Side? Left/Right/Both	How long? Yrs/Months/Days	Describe Pain: Aching, Shooting, Burning/Stabbing/Other	Worse in AM or PM?
Headaches				
Neck Pain				
Jaw Pain				
Ear Pain				
Face Pain				
Eye Pain				
Other				

Does it hurt to chew? \_\_\_\_\_ Open Wide? \_\_\_\_\_  
 Has your jaw ever locked or slipped out of place? \_\_\_\_\_  
 Does your jaw make a popping noise? \_\_\_\_\_ Click? \_\_\_\_\_ Other? \_\_\_\_\_  
 Do you clench or grind your teeth? \_\_\_\_\_ If yes, is it during the day/night/both? \_\_\_\_\_  
 Ear problems? \_\_\_\_\_ Hearing? \_\_\_\_\_ Dizziness? \_\_\_\_\_ Other \_\_\_\_\_  
 Difficulty or painful swallowing? \_\_\_\_\_ Are your teeth sore or sensitive? \_\_\_\_\_

List any injuries to teeth, mouth or face \_\_\_\_\_

Has Patient had: \_\_\_\_\_ Previous Dental Treatment \_\_\_\_\_ Regular Dental Checkups \_\_\_\_\_ Extractions  
 \_\_\_\_\_ Dental X-Rays \_\_\_\_\_ Orthodontic Consultations

Habits (past/present) relating to Mouth or Face – Check all that apply

- |                             |                               |   |
|-----------------------------|-------------------------------|---|
| ____ Thumb (Finger) Sucking | ____ Tooth Grinding/Clenching | ____ Poor Speech Habits                 |
| ____ Blanket Sucking        | ____ Chewing Habits           | ____ Tongue Thrust (Reverse Swallowing) |
| ____ Mouth Breathing        | ____ Lip Biting               | ____ Nail Biting _____ Other            |

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_