



Confidential Patient Information			
First Name:		Middle Initial:	Last Name:
Preferred Name (What would you like us to call you):		Birthdate:	Gender:
Address:		City:	State: Zip:
Best Phone # for calls:	Best Phone # for texts:	Email:	Social Security Number:
If patient is a minor, who is the parent or guardian?		If patient is a minor, who does the patient live with?	
What are the names of any friends or family currently in the practice?			
School:		Grade:	
What are the patient's interests (i.e. sports, hobbies, or musical instruments)?			
Whom may we thank for referring you to our practice?			
What is the patient's main orthodontic concern?			

Financial Party Information			
First Name:		Middle Initial:	Last Name:
Marital Status:		Relationship to Patient:	Birthdate:
Address:		City:	State: Zip:
How long at this address?		Previous address (less than 3 years)?	
Email:	Best Phone # for calls:	Best Phone # for text:	Social Security Number:
Employer:	Occupation:	Length of Employment:	Work Phone:
Spouse or Other Parent's First Name:	Middle Initial:		Last Name:
Relationship to Patient:	Birthdate:	Social Security Number:	
Employer:	Occupation:	Length of Employment:	Work Phone:

Dental Insurance Information			
This section is a very important section and requires a bit more information in order for us to give you a financial breakdown of your estimated treatment cost.			
Policy Holder's Name:	Subscriber DOB:	Relationship to Patient:	Policy Holder's Employer:

Dental Insurance Company Name:	Subscriber ID:	Group Number:	
Dental Insurance Company Address:	City:	State:	Zip:
Dental Insurance Company Phone:			
Do you have dual dental coverage? (If so, complete information below)			
Policy Holder's Name:	Subscriber DOB:	Relationship to Patient:	Policy Holder's Employer:
Dental Insurance Company Name:	Subscriber ID:	Group Number:	
Dental Insurance Company Address:	City:	State:	Zip:
Dental Insurance Company Phone:			

Emergency Contact Information	
Name:	Address:
Relationship to Patient:	Phone:

Dental History		
Dental Name:	Checkup Frequency:	Last Dental Visit:
Has the patient had an orthodontic consult or treatment? If so, when?		
Does the Patient need to premedicate prior to dental visit?		
Please select Yes if the patient has had any of the conditions listed below? Cannot be blank.		
Abnormal swallowing (tongue thrust)?	Apprehensive about dental care?	
Bad taste or mouth odor?	Bleeding gums?	
Brush teeth daily?	Chipped or injured permanent teeth?	
Clench or grind teeth?	Discomfort from teeth or gums?	
Floss teeth daily?	Fluoride treatments?	
Frequent canker sores or cold sores?	Frequently chew gum?	
Frequent headaches?	Frequent sore throats?	
Have wisdom teeth been removed?	Injury to face, jaw, teeth, or mouth?	
Jaw fractures, cysts, or mouth infections?	Missing or extra permanent teeth?	
Mouth breathing?	Neck or shoulder pain?	
Numerous fillings?	Oral habits (thumb or finger sucking, lip or nail biting)?	
Other periodontal (gum) problems?	Pain, tenderness, or noise in either jaw?	

Previous periodontal (gum) treatment?	Previous root canal therapy?
Problems with food trapped between teeth?	Snores during sleep?
Speech problems or therapy?	Teeth sensitive to hot or cold?
Teeth that irritate tongue, cheek, lip, etc.?	Thumb or finger habit as a child?
Is all dental work completed at this time?	
If any of the above dental questions were answered 'Yes', please explain:	
Please select 'Yes' if the patient has had any of the TMJ conditions listed below. Cannot be blank.	
Have you had a TMJ screening?	Do you have a history of jaw joint problems?
Have you been treated for "TMJ"?	Do you notice clicking or popping in your jaw joint?
Has your jaw ever locked?	Do you have difficulty chewing or opening your mouth?
Does your bite feel uncomfortable or unusual?	
Do you experience soreness in the muscles of your face or around your ears?	
If any of the above TMJ questions were answered 'Yes', please explain:	

Medical History			
Physician Name:	Date of Last Physical:	Patient Health:	
Address:	City:	State:	Zip:
Has there been any change in the patient's general health within the last year?			
Is the patient now under the care of a physician (other than routine)? If so, what is being treated?			
Has the patient had a serious illness or hospitalization in the past 5 years? If so, what for?			
Please list any medications currently being taken by the patient (include non-prescription):			
Allergies or drug reaction to:			
Aspirin, Ibuprofen, or Tylenol?	Codeine or other narcotics?	Latex?	
Local anesthetics?	Metal?	Penicillin or other antibiotics?	
Sulfa drugs?	Other?		
Please list any other drug allergies or sensitivities that the patient may have:			

Please select 'Yes' if the patient has had any of the conditions listed below. Cannot be blank.		
Angina?	Anemia or blood disorder?	Arteriosclerosis?
Arthritis or joint problems?	Asthma?	Bed wetting?
Bisphosphonates (Fosamax, Boniva)?	Bone disorders or loss?	Bone fractures or trauma to face or jaw?
Cancer?	Cancer in family history?	Chronic fatigue?
Diabetes?	Emotional problems treatment?	Growth problems?
Handicaps or disabilities?	Heart attack or stroke?	Heart defect (congenital)?
Heart disease?	Heart murmur?	Heart valves are damaged or artificial?
Hemophilia?	High blood pressure or hypertension?	HIV or AIDS?
Hormone therapy?	Kidney disease?	Liver disease, jaundice, or hepatitis?
Low blood pressure?	Nervous disorders?	Persistent cough?
Persistent swollen neck glands?	Pneumonia?	Prolonged bleeding or transfusion?
Prosthetic joints?	Radiation treatment?	Respiratory problems or emphysema?
Rheumatic fever?	Seizures, epilepsy, or neurological disease?	Sexually transmitted disease?
Sinus trouble?	Stomach ulcer or hyperacidity?	Substance abuse problem (past or present)?
Thyroid or endocrine problems?	Tonsils enlarged?	Tonsils or adenoids removed?
Tuberculosis or lung disease?	FEMALES: Are You Pregnant?	
If any of the above medical questions were answered 'Yes', please explain:		

Patients Under 18 (If patient is under the age of 18, please answer the following)	
Height:	Weight:
Has patient begun puberty?	
If patient is a girl, has menstruation begun?	
If patient is a boy, has their voice changed or have facial hair?	
Has the patient grown in the past year or has their shoe size changed recently?	
Has either biological parent ever had orthodontic treatment?	

Acknowledgement of Receipt of Statement of Privacy Practices (HIPAA)

I acknowledge that I have reviewed the [Statement of Privacy Practices](#) for the office of Orthodontics Exclusively. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with the respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Orthodontics Exclusively reserves the right to change the privacy practices that are describe in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revision becomes effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

I agree to permit this patient's photograph or first name to be displayed on office billboards, slideshows, and social media sites. I may advise you in writing if my wishes change.

In addition to the allowable disclosures in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below.

Immediate Family Only:

Other (Please Specify):

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

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

Signature:

Date: