PATIENT INFORMATION FORM

Welcome to our office...

DATE OF EXAM ________________20_________

Please assist us by completing the following questions:

AGE_________________SEX________________

PATIENT'S NAME ____

First *Middle Name* *Last*

DATE OF BIRTH________________________ SOCIAL SECURITY # ________________________

RES. ADDRESS________________________ CITY________________ ZIP__________ PHONE ______________

SCHOOL________________________________ GRADE__________ PHYSICIAN______________________

PATIENT'S DENTIST________________________________ REFERRED BY______________________

MARITAL STATUS OF PARENTS: MARRIED ❑ SINGLE ❑ SEPARATED ❑ DIVORCED ❑ REMARRIED ❑ WIDOWED ❑

PERSON RESPONSIBLE FOR ACCOUNT: ______________________ PATIENT LIVES WITH: BOTH PARENT ❑ MOTHER ❑ FATHER ❑ ADOPTED ❑

ADDRESS____ CITY______________________ ZIP______________

DO YOU HAVE AN INSURANCE PLAN WHICH COVERS ORTHODONTIC TREATMENT? YES ❑ NO ❑ NAME OF COMPANY ________________________

NAMES OF OTHER CHILDREN IN FAMILY EXAMINED AND/OR TREATED?________________________________

FATHER'S NAME____

First *Middle Name* *Last*

DATE OF BIRTH________________ SOCIAL SECURITY #________________________ CELL TELEPHONE________________________

RES. ADDRESS____OCCUPATION________________________

EMPLOYED BY__________________________ HOW LONG HELD________________________

MOTHER'S NAME____

First *Middle Name* *Last*

DATE OF BIRTH________________ SOCIAL SECURITY #________________________ CELL TELEPHONE________________________

RES. ADDRESS____OCCUPATION________________________

EMPLOYED BY__________________________ HOW LONG HELD________________________

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
Diabetes	❑	❑	*Tuberculosis*	❑	❑	*Endocrine or Thyroid Disease*	❑	❑
Pneumonia	❑	❑	*Anemia*	❑	❑	*Prolonged Bleeding*	❑	❑
Heart Abnormalities	❑	❑	*Epilepsy*	❑	❑	*Liver Disease*	❑	❑
Rheumatic Fever	❑	❑	*Asthma*	❑	❑	*Fainting & Dizziness*	❑	❑
Bone Disorders	❑	❑	*Kidney Disease*	❑	❑	*Nervous Disorders*	❑	❑

	YES	NO	?
IS THE PATIENT IN GOOD HEALTH? ________________________	❑	❑	❑
DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? ________________________	❑	❑	❑
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, GIVE REASONS________________________			
DOES THE PATIENT HAVE ANY HISTORY OF LATEX, METAL OR DRUG ALLERGIES/SENSITIVITIES________________	❑	❑	❑
DOES THE PATIENT NEED TO TAKE ANTIBIOTICS BEFORE TEETH CLEANINGS? ________________	❑	❑	❑
HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? ________________	❑	❑	❑
GROWTH IN LAST 6 MONTHS:________________ HAS PATIENT REACHED PUBERTY?________________	❑	❑	❑

HEIGHT: PATIENT'S______ MOTHER'S______ FATHER'S______ PATIENT MOST RESEMBLES: MOTHER ❑ FATHER ❑ BOTH ❑ ADOPTED ❑

DENTAL HISTORY

HAS THERE BEEN ANY INJURES TO THE FACE, MOUTH OR TEETH? ________________	❑	❑	❑
HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE?________________	❑	❑	❑
IS THERE A FAMILY HISTORY OF MISSING OR EXTRA TEETH? ________________	❑	❑	❑
HAS PATIENT HAD ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR EARS?________________	❑	❑	❑
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ________________	❑	❑	❑
HAS THE PATIENT HAD A PREVIOUS ORTHODONTIC EXAMINATION?________________	❑	❑	❑
HAS EITHER PARENT OR OTHER CHILDREN HAD ORTHODONTIC TREATMENT? ________________	❑	❑	❑
DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? ________________	❑	❑	❑
IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? ________________	❑	❑	❑
DOES THE PATIENT WANT ORTHODONTIC TREATMENT?________________	❑	❑	❑
WHEN DID THE PATIENT LAST SEE HIS/HER DENTIST?________________ WERE ANY X-RAYS TAKEN? ________________	❑	❑	❑
DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES? ________________	❑	❑	❑

LIST SPORTS AND HOBBIES____

REASON FOR ORTHODONTIC EXAMINATION____

____

____ Updated 20_____ Initialed ______

Parent's Signature *Date* 20_____ ______

20_____ ______

CENTRAL LAKES ORTHODONTICS, P.A.
TODD G. ANDERSON, D.D.S.