

Patient Information

Date _____

Patient's name _____

Last
First
Middle

Address _____

Street
City
Zip

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____

Last
First
Middle

Residence _____

Street
City
Zip

Mailing Address _____

Street
City
Zip

How long at this address? _____ Home phone _____ Work phone _____

Previous Address (If less than 3 years) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____

Street
City
Zip

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Phone # (_____) _____ - _____ Address _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Are you allergic to any medication? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any major operations? _____
- Yes No Have you ever been involved in a serious accident? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------------|---------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy or Convulsions | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hay fever | Gastrointestinal Disorders | HIV / Aids | Rheumatic / Scarlet Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis (TB) |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
| ADD / ADHD | Allergy to Latex | Artificial Bones-Joints-Valves | Hearing Impairment |

Are there any medical or psychological conditions not covered above that you feel we should be aware of? _____

DENTAL HISTORY

Dentist _____ Date of last visit _____

What concerns you most about your smile and teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have there been any injuries to face, mouth or teeth? _____
- Yes No Have you been informed of any missing or extra permanent teeth? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb / finger or tongue habit? _____ lip biting habit? _____
- Yes No Are there any speech problems? _____
- Yes No Are you a mouth breather? _____
- Yes No Have adenoids and/or tonsils been removed? If yes, when? _____
- Yes No Have you ever seen an orthodontist? If yes, when and who? _____
- Yes No Would you object to wearing orthodontic appliances (braces) should they be indicated? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- How did they feel about the result? _____
- What is patient's interest in receiving orthodontic treatment?
 Eager for treatment Willing if needed Dreading but agrees Unwilling
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Have you ever experienced pain or tenderness in the jaw joint (TMJ / TMD)? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No If the patient is under age 16, height of parents? Mom _____ Dad _____
- Yes No Are you aware that some appointments will be during school/work hours? _____
- Please list some hobbies or interests _____
- Female Patients only:
- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Nowlin to perform a complete orthodontic evaluation.

Signature: _____ Date: _____