edwards&schaefer ORTHODONTICS

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY
Welcome to our office! Please fill out both pages of this form

TELL US ABOUT YOUR CHILD

Patient Name: _____ Prefers to be called: _____ Age: ____ Birth Date: _____ Sex: _____

Address: _____ School: _____ Grade: _____

_____ Hobbies/Sports: _____

Who may we thank for referring you to our office: _____

FAMILY HISTORY

	PARENT/GUARDIAN	PARENT/GUARDIAN
Name:	_____	_____
Address:	_____	_____
	_____	_____
Phone (home):	_____	_____
Phone (cell):	_____	_____
Phone (work):	_____	_____
Employer:	_____	_____
E-mail Address:	_____	_____

Marital Status of Parents: Married [ ] Divorced [ ] Separated [ ] Other: _____

Patient living with: Mother [ ] Father [ ] Both [ ] Other: _____

Other children in the family (name & age): _____

MEDICAL HISTORY

Name of Patient's Physician: _____ City: _____

Is the patient in good health at this time: Y [ ] N [ ]

Is the patient under the care of a physician for an illness? Y [ ] N [ ] If yes, please explain: _____

Is the patient taking any medications? Y[ ] N [ ] Name and for what condition: _____

Does the patient have any allergies? Y[ ] N[ ] If yes, please specify allergy: _____

Does the patient have or have a history of any of the following conditions? Please check all that apply

___ Abnormal Bleeding	___ Cold Sores	___ Headaches/migraines	___ Kidney/Liver Disease
___ Arthritis	___ Diabetes	___ Heart condition/murmur	___ Previous surgery
___ Artificial joint/valve	___ Dizziness/fainting	___ Head/face injury	___ Rheumatic fever
___ Asthma	___ Emotional problems	___ Hepatitis	___ Sinus problems
___ Birth/congenital defects	___ Endocrine problems	___ Herpes	___ Thyroid problems
___ Cancer	___ Epilepsy/seizures	___ HIV Positive	___ Tuberculosis

Other: _____

_____

Does the patient require antibiotics prior to dental procedures? Y [ ] N [ ]

Has the patient ever been hospitalized or had a serious injury? Y [ ] N [ ]

If yes, please explain: _____

Has the patient reached puberty (menstruation, voice changes, facial hair growth)? Y [ ] N [ ] If yes, at what age ____

Females, does the possibility of pregnancy exist? Y [ ] N [ ]

DENTAL HISTORY

Name of Patient's dentist: _____ City: _____ Date of last visit: _____

Why are you and your child seeking orthodontic consultation? _____

Does anyone else in the family have a similar dental condition for which you are seeking treatment? Y [ ] N [ ]

Has the patient had a previous orthodontic consultation? Y [ ] N [ ] or orthodontic treatment? Y [ ] N [ ]

Date: _____ Doctor: _____ City: _____

Have other family members had orthodontic treatment? Y [ ] N [ ] Are you satisfied with the results? Y [ ] N [ ]

Has the patient ever sucked his/her finger, thumb, or pacifier? Y [ ] N [ ] If yes, when did this habit stop? _____

Does the patient have any facial or jaw pain, clicking, or popping of the jaw joint? Y [ ] N [ ]

Does the patient grind or clench his/her teeth? Y [ ] N [ ]

Does the patient have or have a history of difficulty opening his/her mouth? Y [ ] N [ ]

Has the patient ever had his/her jaw lock open or closed? Y [ ] N [ ]

BILLING INFORMATION

Financially Responsible Party:

Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: Home: _____ Work: _____ Cell: _____ Soc.Sec.#: _____

Primary Dental Insurance Information:

Subscribers Name: _____ Social Security #: _____ Birth Date: _____

Insurance Company: _____ Group #: _____ Enrollee ID #: _____

Employer Name: _____ Insurance Phone #: _____

Secondary Dental Insurance Information:

Subscribers Name: _____ Social Security #: _____ Birth Date: _____

Insurance Company: _____ Group #: _____ Enrollee ID #: _____

Employer Name: _____ Insurance Phone #: _____

Signature: _____ Relationship to Patient: _____ Date: _____

Update Signature: _____ Relationship to Patient: _____ Date: _____

Update Signature: _____ Relationship to Patient: _____ Date: _____