



We are pleased that you selected our office for your orthodontic treatment. At this appointment a preliminary orthodontic evaluation and diagnosis will be done. Please complete form below. Thank you.

General Information

Patient's Name: _____ Sex: M F Birth Date: ___/___/___

Address: _____ Phone: _____

Name of person completing this form: _____ Relation To Patient: _____

Who first noticed orthodontic problem: _____

Your Chief Concern for us to address: _____

Do you have insurance that covers orthodontic treatment No ? Yes Soc. Sec. No.: _____

Subscriber's Last, First Name: _____ Subscriber's #: _____

Name of Insurance Company: _____ Group: _____ Plan: _____

(Please bring insurance forms or information with you. Thank you.)

Medical History Summary		Please Circle	(Personal Physician _____)
Heart Problems?	yes	no	Heart Diseases: _____
Chronic Diseases?	yes	no	Diseases: HIV+ _____ AIDS _____ HEPATITIS _____ Other: _____
Presently in Treatment?	yes	no	For: _____
Presently using Medications?	yes	no	Medication: _____
Allergies/Drug reactions?	yes	no	Allergies: <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Other Drugs: _____ <input type="checkbox"/> Asthma
Operation/Hospitalization?	yes	no	for: <input type="checkbox"/> Tonsils <input type="checkbox"/> Adenoids <input type="checkbox"/> Other Hospitalizations: _____
Breathing Problems?	yes	no	Breathe mostly through: <input type="checkbox"/> Mouth <input type="checkbox"/> Nose <input type="checkbox"/> Comments: _____
Speech Problems?	yes	no	Lisping Had speech Therapy? Y N Comments: _____
Oral Habits?	yes	no	<input type="checkbox"/> Grinding <input type="checkbox"/> Clenching <input type="checkbox"/> Tongue Thrust <input type="checkbox"/> Thumb/Finger
Headaches or Pains?	yes	no	Headaches _____ times/month Describe: _____
Females Only:			
Are you pregnant?	yes	no	If No, are planning on becoming? <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/> Yes
Child Only:			
Has child reached puberty?	yes	no	If Yes, at age ____ Has a physician indicated that this child is Maturing: <input type="checkbox"/> Early <input type="checkbox"/> Normal <input type="checkbox"/> Late?
Other Medical Problems	yes	no	_____

* PLEASE COMPLETE OTHER SIDE *

