Patient Information

Date_____

Patient's name_____
Last First Middle

Address _____
Street City Zip

Gender: Male/Female Birthdate_____ Age _____ Home #_____Cell #_____

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

Sports/hobbies_____ Other family members treated here _____

Attends School at_____ Grade_____ E-mail _____

Responsible Party Information

Name_____
Last First Middle

Residence _____
Street City Zip

Mailing Address_____
Street City Zip

Home # _____ Work # _____ Cell #_____

Relationship to Patient_____ Employer_____ Occupation_____

Spouse's Name_____ Employer_____ Occupation_____

Work #_____ Cell # _____ E-mail_____

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 _____

MEDICAL HISTORY

Physician _____ Phone _____

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

Yes No Have you ever taken any biphosphonates (Fosamax, Zomata, etc.) for osteoporosis, osteitis deformans ("Paget's disease of bone"), bone metastasis, multiple myeloma or any other conditions that feature bone fragility? _____
Yes No Are you taking any medications? _____
Yes No Are you allergic to anything? _____
Yes No Have you ever had an unusual reaction to any drug? _____
Yes No Have you had any major illness or operation? _____
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	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Dentist _____ Date of last visit _____
What is the primary concern about your teeth, bite, or appearance that brings you in today? _____
_____

Yes No Are you presently in any dental pain? _____
Yes No Have there been any injuries to your face, mouth or teeth? _____
Yes No Do your gums bleed when you brush or have you been told you have perio disease? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? If yes, who and when? _____
Yes No Has anyone in your family received orthodontic treatment? _____
What is your attitude toward receiving orthodontic treatment? _____
Yes No Do your teeth or jaw muscles ever feel sore or tired in the morning? _____
Yes No Are you aware of any TMJ pain, clicking or popping? _____
Yes No Are you aware of clenching or grinding your teeth during the day or night? _____
Yes No Are you as tall as your same gender parent? _____
Females only:
Yes No Are you or could you be pregnant? _____

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 very 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 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. Huse to perform a complete orthodontic evaluation.

Signature: _____ Date: _____