ORTHODONTIC RECORD

Patient Name	Street	City	State	Zip

Phone	Cell Phone	Age	Sex	Social Security #	Birth Date

E-mail	Employer	Employer's Phone

Dentist	Referred by

Spouse	Social Security #	Street	City	State	Zip

Phone	Cell Phone	Employer	Employer's Phone

ORTHODONTIC INS. COVERAGE _______________
POLICY HOLDER ______________________________
POLICY #____________________________________
GROUP # ____________________________________
POLICY HOLDER'S BIRTH DATE________________

INS. COMPANY ____
ADDRESS ____
____
PHONE____

DENTAL HISTORY:

1) Patient's last dental visit: _______________________ Do you have any dental procedures in progress? Yes or No

2) How often do you brush your teeth? _________________________ How often do you floss your teeth? ___________________________________

3) Do you have (please circle): TMJ concerns grinding of teeth thumb-sucking habit tongue thrusting habit gum disease ____________________

4) What concerns you about your teeth? ____

____

____

5) Why did you select our office? ____

6) How many months of treatment would you be able to commit to for orthodontic care? ______________________

7) Who suggested that you might need orthodontic care? ____

8) Have any other family members received orthodontic care in our office? ______ If yes, who? ____

MEDICAL HISTORY:

1) Please circle if you have any history of: heart disease osteoporosis HIV mental illness bleeding disorder eating disorder frequent headaches
other __________________________________

2) Please list any allergies you have, including allergies to medications: ____

____

3) What medications are you taking? ____

4) I have these medical disorders: ____

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DOCTOR'S NOTES: