ORTHODONTIC RECORD

Name			Address			Phone
E-mail	Birth Date	Age	Sex	Grade		Patient Cell #

Father/Husband	Cell Phone #	Address	Employed by	Work Phone
Mother/Wife	Cell Phone #	Address	Employed by	Work Phone

Place of employment (if adult patient)	Address of employer	Business Phone

Dentist	Physician	Referred by

ORTHODONTIC INS. COVERAGE? _______________
POLICY HOLDER _______________
POLICY # _______________
GROUP # _______________
POLICY HOLDER'S BIRTH DATE _______________

INS. COMPANY _______________
ADDRESS _______________
____
PHONE # _______________

DENTAL HISTORY:

1) Patient's last dental visit: List any dental procedures in progress:
2) How often do you brush your teeth? What is your level of interest in orthodontic care: Very Moderate Low
3) Do you have (please circle): TMJ concerns grinding 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: _______________

DOCTOR'S NOTES:

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