Choice Orthodontics
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Orthodontic Patient Information Sheet: About You

Name: ____

Preferred Name: ______________________________ Gender: ____________________

Date Of Birth: ______________________________ Age: ________________________

SSN: ________________________ Home Phone: ______________________________

Cell Phone: ____________________ Cell Phone Carrier: _______________________

Home Address: ____

City: ______________________________ State: __________ Zip: __________________

Email: ____

Employer: ____________________________ Work Phone: _____________________

How Did You Hear About Us: ____

Orthodontic Insurance

	Primary	Secondary
Subscriber Name:	________________________	________________________
Subscriber ID (SSN):	________________________	________________________
Subscriber Date Of Birth:	________________________	________________________
Relationship:	________________________	________________________
Employer:	________________________	________________________
Employer Phone Number:	________________________	________________________
Employer Address:	________________________	________________________
Insurance Carrier:	________________________	________________________
Group Number:	________________________	________________________

Medical History

Physician: ____________________________________ Date of Last Visit: ______________

Are You Currently Under The Care Of A Physician? ____Y ____N

Describe Your Physical Health: ____Good ____Fair ____Poor

List Any Medications You Are Currently Taking: ________________________________

List Any Medications You Are Allergic To: ____________________________________

Have You Ever Taken Or Are You Currently Taking Bisphosphonates? ____Y ____N

Please List Any Medical Conditions You Have: __________________________________

(Please complete other side)

Have You Had Any Of The Following Medical Problems?

Y N Allergic to Latex/Metals/Plastic
Y N Any Hospital Stays/Operations
Y N Asthma
Y N Blood Disorder
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Heart Valve Defect
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Previous Infective Endocarditis
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis
Other___________________________

Do You Need To Be Pre-medicated Before Dental Treatment? ____Y ____N

Dental History

Do You Have A Specific Orthodontic Concern You Want The Doctor To Address? ______________
Have You Previously Had An Evaluation for Orthodontic Treatment? ____Y ____N
Have There Been Any Injuries To The Face, Mouth, Teeth Or Chin? ____Y ____N
Have Adenoids or Tonsils Been Removed? ____Y ____N
Have You Been Informed Of Any Missing Or Extracted Teeth? ____Y ____N
Has There Been Any Pain In Your Jaw Joint (TMJ/TMD)? ____Y ____N
Do Your Brush Your Teeth Daily? ____Y ____N
General Dentist: _________________________________ Date Of Last Visit: ___________________
Do We Have Permission To Send Information To Your Dentist? ____Y ____N

Do You Have Any Of The Following Habits?

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Speech Problems
Y N Thumb/Finger Sucking
Y N Tongue Thrust

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform necessary dental services I may need.

Signature: ____ Date: __________________