PINE TOP
ORTHODONTICS
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Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip Code

Home Phone: _____ Birthdate: _____ Age: _____

Who is your General Dentist?: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status

Relationship to Patient: _____

Address (if different from above):

_____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address (for confirmation of appts ONLY): _____

Spouse: _____
Last First Middle

Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: (confirmation of appts only) _____

How would you prefer to be contacted for appointment reminders (i.e., phone, text, e-mail)? _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ SS or ID #: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

Do you have dual coverage? If yes:

Insured's Name: _____ SS or ID #: _____ Birthdate: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip Code

Insured's Employer: _____

(Continued on back)

DENTAL HISTORY

What are the main goals you would like orthodontics to accomplish?

How many months has it been since your last dental check-up? ____

Have you ever had a negative dental experience?	Y	N
Have you been evaluated or had orthodontic treatment?	Y	N
Do you feel that your teeth are too small or short?	Y	N
Do you feel that your teeth are too large or long?	Y	N
Do you feel that your teeth are too crooked or crowded?	Y	N
Do you feel that your teeth are misshaped (uneven/pointed	Y	N
Do you feel there is too much or too little gum tissue showing when you smile?	Y	N
Do you have any missing, extra, or impacted teeth?	Y	N
Have your adenoids or tonsils been removed?	Y	N
Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)?	Y	N
Do you have any speech problems?:	Y	N

HABITS

Did you or do you have any of the following habits?:

Clenching/Grinding teeth	Y	N	Thumb/Finger sucking	Y	N
Lip sucking/biting	Y	N	Tongue thrust	Y	N
Mouth breather	Y	N	Nail Biting	Y	N

MEDICAL HISTORY

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Arthritis	Y	N	Handicaps/Disabilities	Y	N
Asthma	Y	N	Hearing impairment	Y	N
Bleeding disorder	Y	N	Heart problems	Y	N
Blood pressure problems	Y	N	Hepatitis	Y	N
Chemo/Radiation	Y	N	Kidney/Liver defects	Y	N
Convulsions/Epilepsy	Y	N	Mitral valve prolapse	Y	N
Diabetes	Y	N	Sinus problems	Y	N
Fever blisters/Cold sores	Y	N			

Are you taking any medications? Y N

If yes, please list each one: ____

Have you ever taken bisphosphonate drugs (Fosamax, Boniva) used to treat osteoporosis or multiple myeloma)? Y N

For Women: Are you pregnant? Y N

If yes, Week #: ____

Are you allergic to any of the following?:

Aspirin	Y	N	Latex	Y	N
Any metals	Y	N	Penicillin	Y	N
Codeine	Y	N	Tetracycline	Y	N
Dental Anesthetics	Y	N	Erythromycin	Y	N

Other: ____

Please elaborate on any other dental or medical concerns: ____

Signature (Parent/Guardian if minor): ____ Date: ____

Reviewed by Dr. Ford/Dr. Frost: ____ Date: ____