

New Patient



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GENERAL INFORMATION

Patient's Name _____
Last First Middle Preferred Nickname
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Age _____ Sex: M F
Whom may we thank for referring you to our office? _____
Please describe the orthodontic problem in your own words _____

IF PATIENT IS A MINOR

School _____ Grade _____
Special Interests: hobbies, sports, etc. _____

Parent's Marital Status Married Separated Divorced Widowed Single

Father's Name _____
Last First Middle
Address (if different than above) _____
Street City State Zip
Home Phone (if different than above) _____ Work Phone _____
Social Security# _____ DOB _____ Cell Phone _____
Employer _____ Occupation _____
E-mail _____

Mother's Name _____
Last First Middle
Address (if different than above) _____
Street City State Zip
Home Phone (if different than above) _____ Work Phone _____
Social Security # _____ DOB _____ Cell Phone _____
Employer _____ Occupation _____
E-mail _____

Patient lives with: Mother & Father Mother Father Other _____
Name of Step Parent(s) (if applicable) _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relation _____
Home Phone _____ Work Phone _____

IF PATIENT IS AN ADULT

Social Security# _____ Work Phone _____
E-mail _____ Cell Phone _____
Employer _____ Occupation _____

Spouse's Name _____
Last First Middle
Address (if different than above) _____
Street City State Zip
Home Phone (if different than above) _____ Work Phone _____
Social Security# _____ DOB _____ Cell Phone _____
E-mail _____
Employer _____ Occupation _____

RESPONSIBLE PARTY, if other than parent(s), or patient

Name(s) _____
Last First Middle
Address (if different than above) _____
Street City State Zip
Home Phone (if different than above) _____ Work Phone _____
Social Security# _____ DOB _____ Cell Phone _____
Employer _____ Occupation _____
E-mail _____ Relation to Patient _____

(continued on back)

Are there any cultural, learning or language barriers we need to be aware of? Yes No
 Language: English Spanish Other _____ Translator Needed
 Learning variables: None Hearing Vision Cognitive Impairment Illiterate Pain Anxiety

PATIENT DENTAL HISTORY

Patient's dentist _____

Has your dentist talked to you about an orthodontic concern? Yes No

Date of last dental cleaning: _____

Has all recommended dental work been completed? Yes No

Check if patient has or has had:

- Extra teeth High rate of tooth decay
- Missing teeth Teeth sensitive to hot, cold, or sweets
- Gum disease or infection Frequent canker sores
- Herpes (fever blisters) Tooth extraction

Check all that apply to patient	Yes	If Yes, please explain
Prior orthodontic evaluation		
Prior orthodontic treatment		
History of thumb / finger sucking		
History of nail biting		
Plays musical instrument		
Breaths with mouth open		
Has a severe injury to the head, face, or teeth		
Noise or pain in jaw joint (TMJ)		
Treatment for a jaw joint problem		
History of clenching or grinding the teeth		
Frequent headaches		

PATIENT MEDICAL HISTORY

Patient's physician _____

Date of last medical exam: _____

	Yes	If Yes, please explain
Under a physician's care		
Any allergies		
Taking any medication(s)		List / Explain:
Had an unfavorable reaction to any medication(s)		List:
Had a serious illness or medical condition		
Mentally or physically challenged		
Required antibiotic premedication for a dental appointment		

Please check any of the following which the patient has or has had:

- High blood pressure Asthma
- Heart disease Tonsils and/or Adenoids removed
- Rheumatic/Scarlet fever Difficulty breathing through the nose
- Heart murmur Cleft lip and/or Cleft palate
- Bleeding problems/Blood disorder Speech problems/Speech therapy
- Arthritis Hearing problems
- Bone disorders Epilepsy/Convulsions
- Prosthetic joint (replacement) Nervous/Anxious
- Malignancies, tumors, cancers Latex allergy
- Liver problems/Hepatitis Nickel/Metal allergy
- Tuberculosis AIDS or HIV Positive
- Diabetes Bisphosphonate Medication
- Tobacco use / Frequency _____

MINOR PATIENT GROWTH INFORMATION (if known)

Height of: Patient _____ Father _____ Mother _____

Patient's brothers and sisters:

- Name _____ Age _____
- Name _____ Age _____
- Name _____ Age _____
- Name _____ Age _____

Has any member of the family had orthodontic treatment? If yes, who and where? _____

Has the patient:

- Reached puberty (generally signalled by voice changing in boys and menstrual cycle in girls) Yes No
- Had growth or developmental disorder Yes No
- Had unusual growth rates Yes No
- Family history of similar facial growth pattern Yes No
- Been adopted Yes No

Are there any other dental or medical concerns of which we should be aware?

This information is complete and accurate.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any about the inquiries set forth above have been answered to my satisfaction. I will not hold my orthodontist or any other member of his / her staff, responsible for any error or omissions that I have made in the completion of this form. If any information changes, I will notify Ellingsen • Paxton • Johnson Orthodontics immediately.