Patient Information

Patient's name _____
Last First Middle

Address _____
Street City Zip

Home Phone _____ Cell Phone (Parent's # if patient is a minor) _____

Patient's Birthdate _____ Email (Parent's email if patient is a minor) _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing (if different) _____
Street City Zip

Relationship to Patient _____ Cell Phone _____

Employer _____ Work phone _____

Spouse's Name_____
Last First Middle

Relationship to Patient _____ Cell Phone _____

Employer _____ Work phone _____

Dental Insurance Information

Subscribers Name _____ Birthdate _____

Employer _____ Insured's Social Security or ID # _____

Insurance Company _____ Group # _____

Insurance Address _____ Phone # _____

Do you have dual insurance coverage? Yes_____ No_____ IF YES, please let us know so we can gather the necessary information.

If I choose to have orthodontic treatment at Jones Family Orthodontics, I hereby authorize Jones Family Orthodontics to bill my insurance company directly and I assign the benefit of direct payment of dental benefits otherwise payable to me, directly to Jones Family Orthodontics and Graham Jones, D.D.S., M.S.D., P.S.

Authorized Signature _____ Date _____

Emergency Information

Name (other than parent/guardian) _____

Home Phone _____ Cell Phone _____

Medical History

Physician _____ Phone _____ Date of Last Visit _____

Yes No Are you taking any medication? (Specify) _____

Yes No Do you use tobacco? If yes, how much _____

Yes No Do you have a history of a major illness? (Specify) _____

Yes No Have you had any major operations? (Specify) _____

Yes No Have you ever been involved in a serious accident? (Specify) _____

Yes No Do you have any developmental delays or learning disabilities? (Specify) _____

Yes No Do you have any mental or physical conditions which may affect your dental or orthodontic care? (Specify)

_____

Are you allergic to any of the following:

Yes	No	Local Anesthetics (Novocaine or Lidocaine)	Yes	No	Aspirin
Yes	No	Latex (gloves, balloons)	Yes	No	Ibuprophen (Motrin, Advil)
Yes	No	Metals (Jewelry, clothing snaps, nickel)	Yes	No	Penicillin or other antibiotics
Yes	No	Acrylic	Yes	No	Sulfa Drugs
Yes	No	Codeine or other narcotics	Yes	No	Foods (Specify) _____

Other Allergies (Specify) _____

Do you now have or have you ever had any of the following? (Please Circle)

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Endocarditis	High Blood Pressure	Prosthetic Heart Valve
Asthma or Hayfever	Epilepsy	HIV / Aids	Radiation/Chemotherapy
Bone Disorders	Gastrointestinal Disorders	Kidney problems	Rheumatic Fever
Congenital Heart Defect	Heart Problems	Nervous Disorders	Tuberculosis
	Heart Murmur		Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

Dental History

Name of your Dentist _____ Date of last visit _____

Please explain why you are seeking orthodontic treatment: _____

What is your attitude toward receiving orthodontic treatment? _____

How often do you brush? _____ Floss? _____ Use Mouthwash? (specify brand) _____

Yes No Are you presently in any dental pain?_____

Yes No Have you ever experienced any unfavorable reaction to dentistry?_____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth?_____

Yes No Is any part of your mouth sensitive to temperature or pressure?_____

Yes No Do your gums bleed when you brush?_____

Yes No Have you had periodontal (gum) disease? _____

Yes No Do you have any type of thumb, finger, or tongue habit?_____

Yes No Are you a mouth breather? _____

Yes No Have you ever seen an orthodontist? If yes, who and when?_____

Yes No Has anyone in your family received orthodontic treatment?_____

How did they feel about the result?_____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____

Yes No Are you aware of your jaw clicking or popping?_____

Yes No Are you aware of clenching your teeth during the day?_____

Yes No Have you ever been told that you grind your teeth? _____

Yes No Do you have "tension" headaches?_____

Yes No Have you ever experienced chronic ringing in your ears or locking of the jaws?_____

Yes No Are you aware that some appointments will be during school/work hours? _____

Yes No Are you concerned about your jaw being overdeveloped/underdeveloped? _____

Yes No Are you aware that orthodontics can change your facial profile? _____

Yes No Would you like to change your facial profile? If so, in what way_____

Female Patients only: Has menstruation started? Yes No (specify age) _____ Are you pregnant? Yes No

I have read and understand the above questions. I will not hold my orthodontist or any members of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature: _____ Date: _____