CEDAR PARK Orthodontics

**Date:** **Patient Information**

PATIENT'S NAME..... NICKNAME..... ☐ MALE ☐ FEMALE

AGE..... BIRTH DATE...../...../..... SOCIAL SECURITY #..... PATIENT'S/PARENT'S E-MAIL.....

ADDRESS..... CITY, STATE, ZIP CODE.....

HOME PHONE..... CELL PHONE..... WORK PHONE.....

FAMILY DENTIST..... LAST CLEANING..... LAST SEEN.....

IS ANY DENTAL WORK PENDING? ☐ YES ☐ NO PLEASE DESCRIBE.....

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?.....

SCHOOL..... GRADE..... HOBBIES/SPORTS.....

SIBLINGS/CHILDREN INFORMATION

NAME..... SEX..... BIRTHDATE.....

NAME..... SEX..... BIRTHDATE.....

NAME..... SEX..... BIRTHDATE.....

NAME..... SEX..... BIRTHDATE.....

## Responsible Party Information

FULL NAME..... MARITAL STATUS.....

ADDRESS..... CITY, STATE, ZIP CODE.....

MAILING ADDRESS..... CITY, STATE, ZIP CODE.....

HOW LONG AT THIS ADDRESS?..... HOME PHONE..... CELL PHONE..... WORK PHONE.....

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS)..... CITY, STATE, ZIP CODE.....

SOCIAL SECURITY #..... BIRTH DATE..... RELATIONSHIP TO PATIENT.....

EMPLOYER..... OCCUPATION..... # YEARS EMPLOYED.....

SPOUSE'S FULL NAME..... RELATIONSHIP TO PATIENT.....

SOCIAL SECURITY #..... BIRTH DATE..... CELL PHONE..... WORK PHONE.....

EMPLOYER..... OCCUPATION..... # YEARS EMPLOYED.....

## Dental Insurance Information

INSURED'S FULL NAME..... INSURED'S MEMBER ID#.....

INSURANCE COMPANY..... GROUP #..... PHONE #.....

INSURANCE CO ADDRESS..... EMPLOYER.....

DO YOU HAVE DUAL COVERAGE? ☐ YES ☐ NO 2ND INSURED'S FULL NAME..... DOB.....

INSURNCE COMPANY..... INSURED'S MEMBER ID#..... GROUP #.....

## Emergency Information

EMERGENCY CONTACT..... HOME PHONE.....

CELL PHONE..... RELATIONSHIP TO PATIENT.....

Signature ( Parent's signature, if minor)..... Date: .....

# Please complete the following health questionnaire as fully and completely as possible. Also write in any other information that you feel might be helpful.

WHAT ARE THE PATIENT'S OR PARENTS MAIN CONCERNS REGARDING THE JAWS AND TEETH?

- ☐ CROWDING
- ☐ OVERBITE
- ☐ BUCK TEETH
- ☐ MISALIGNMENT
- ☐ RECEDED JAW
- ☐ PROMINENT JAW
- ☐ GUMMY SMILE
- ☐ SPACING
- ☐ GUM DISEASE
- ☐ MOUTH TOO SMALL
- ☐ CLICKING JAW JOINT
- ☐ IRREGULARLY SHAPED TEETH
- ☐ PROTURSION OF TEETH
- ☐ RINGING IN EARS
- ☐ HEADACHES/FACIAL PAIN
- ☐ NECK PAIN
- ☐ JAW PAIN
- ☐ IRREGULAR FACIAL PROPORTIONS
- ☐ CROSSBITE
- ☐ UNDERBITE
- ☐ OPENBITE
- ☐ FINGER/THUMB SUCKING HABIT
- ☐ TO SEE IF ORTHODONTICS IS NEEDED
- ☐ TRANSFER IN CONTINUE TREATMENT
- ☐ SECOND OPINION
- ☐ DENTIST RECOMMENDED
- ☐ OTHER.....

.....

PATIENTS CURRENT PHYSCAL HEALTH?

..... EXCELLENT ..... FAIR
..... GOOD ..... POOR

PATIENTS CURRENT MENTAL HEALTH?

..... EXCELLENT ..... FAIR
..... GOOD ..... POOR

LIST ALL CURRENT MEDICATIONS TAKEN BY PATIENTS?

..... HEART PILLS .....
..... ANTIBIOTICS .....
..... PAIN PILLS .....
..... BIRTH CONTROL PILLS.....
..... ANTI-ANXIETY/ANTIDEPRESSANTS
.....
..... BISPHOSPHONATES .....
..... OTHER .....
.....

HAS THE PATIENT EVER HAD , OR NOW HAVE ANY OF THE FOLLOWING CONDITIONS?

- ☐ ANEMIA
- ☐ BLOOD DISEASE
- ☐ PROLONGED BLEEDING
- ☐ HEPATITIS
- ☐ AIDS OR HIV POSITIVE
- ☐ RHEUMATIC FEVER
- ☐ MALIGNANCIES, TUMORS, OR CANCER
- ☐ HEART DISEASE OR MURMUR
- ☐ TURBERCULOSIS
- ☐ DIABETES
- ☐ ENDOCRINE PROBLEMS
- ☐ BONE DISORDERS
- ☐ EPILEPSY
- ☐ TONSILITIS
- ☐ MONONUCLEOSIS
- ☐ TONSILS REMOVED
- ☐ ADENOIDS REMOVED
- ☐ ASTHMA
- ☐ AUTOIMMUNE
- ☐ HIGH BLOOD PRESSURE
- ☐ SLEEP DISTURBANCE
- ☐ EATING DISORDER
- ☐ MOUTH BREATHING
- ☐ LOUD SNORING
- ☐ ALLERGY: SEASONAL
- ☐ ALLERGY: PENICILLIN
- ☐ ALLERGY: LATEX
- ☐ ALLERGY: NICKEL
- ☐ ANTIBIOTIC PERMEDICATION
- ☐ SEVER HEAD OR FACIAL INJURY
- ☐ FINGER/THUMBSUCKING HABIT
  CURRENT ..... PREVIOUS .....
- ☐ BITES NAILS
- ☐ PLAYS MUSICAL WIND INSTRUMENTS
- ☐ PREVIOUS TMJ TREATMENT
- ☐ FAMILY HISTORY ORTHOGNATHIC SURGERY
- ☐ REPAIRED CLEFT LIP/PALATE
- ☐ OSTEOPOROSIS

IF A CHILD HAS THE PATIENT REACHED PUBERTY?

..... YES (APPROXIMATE DATE .....)
..... NO

HOW OFTEN DOES THE PATIENT HAVE DENTAL CHECKUPS?

..... ONCE PER YEAR
..... TWICE PER YEAR
..... MORE THAN TWICE PER YEAR
..... ONLY IF URGENT (EMERGENCY VISIT)
..... NEVER

DOES THE PATIENT HAVE DIFFICULTY CHEWING?

..... YES
  ..... TEETH DON'T MEET WELL
  ..... PAIN WHEN CHEWNG
  ..... OTHER .....
..... NO

DOES THE PATIENT HAVE PAIN/CLICKING IN THE JAW JOING?

..... YES
  ..... RIGHT
  ..... LEFT
..... NO

HAS THE PATIENT EVER BEEN TOLD THEY HAVE A TONGUE THRUST SWALLOWING PATTERN?

..... YES
..... NO
..... UNCERTAIN

DOES THE PATIENT GRIND/CLENCH THE TEETH?

..... YES
..... NO
..... UNCERTAIN

HAS THE PATIENT HAD A PREIVOUS ORTHODONTIC EXAMINATION/CONSULTATION?

..... YES (WHEN .....)
..... NO

WHAT IS THE PATIENT'S INTEREST IN ORTHODONTIC TREATMENT?

..... WANTS TREATMENT
..... TREATMENT ONLY IF NECESSARY
..... UNWILLING, BUT WILL COOPERATE IF TREATMENT IS NEEDED
..... UNCOOPERATIVE

ARE THERE ANY MEDICAL, DENTAL, OR SURGICAL PROBLEMS WHICH HAVE NOT BEEN COVERED ON THIS FORM?

..... YES
.....
.....
.....
..... NO

SIGNATURE OF PERSON FILLING OUT FORM

PRINTED NAME

DATE

DOCTOR'S NOTES: