MAI ORTHODONTICS

DATE:

## patient information

PATIENT NAME..... (LAST / FIRST / MIDDLE / NICKNAME)

ADDRESS..... (STREET / CITY / STATE / ZIP)

HOME PHONE.....BIRTH DATE.....AGE.....SEX.....SOCIAL SECURITY #.....

IF PATIENT IS A MINOR, GIVE PARENT'S/GUARDIAN'S NAME.....

FAMILY DENTIST.....WHEN LAST SEEN?.....

IS ANY DENTAL WORK PENDING?.....PLEASE DESCRIBE.....

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

SCHOOL.....

SIBLING/CHILDREN INFORMATION:

NAME.....SEX.....DOB.....AGE.....

NAME.....SEX.....DOB.....AGE.....

NAME.....SEX.....DOB.....AGE.....

## responsible party information

NAME..... (LAST / FIRST / MIDDLE)

EMAIL ADDRESS.....MARITAL STATUS.....

RESIDENCE..... (STREET / CITY / STATE / ZIP)

MAILING ADDRESS..... (STREET / CITY / STATE / ZIP)

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

PREVIOUS ADDRESS (if less than 3 years)..... (STREET / CITY / STATE / ZIP)

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

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

SPOUSE'S NAME..... (LAST / FIRST / MIDDLE)RELATIONSHIP TO PATIENT.....

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

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

## dental insurance information

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

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

INSURANCE CO. ADDRESS.....

DO YOU HAVE DUAL COVERAGE? YES....NO..... IF YES, PLEASE COMPLETE THE FOLLOWING:

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

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

INSURANCE CO. ADDRESS.....

INSURED'S EMPLOYER.....

## emergency information

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

COMPLETE ADDRESS.....

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 CHILD'S MEDICAL STATUS.

_____

Signature of parent or guardian Date

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**Please FULLY complete the following health questionnaire.**

## health status

**Main concerns** regarding the jaws and teeth.....

Patient's current **physical** health.....

Patient's current **mental** health.....

All **current medications** taken by patient.....

Has **puberty** begun? YES..... NO.....

FEMALES:

Has **menstruation** begun? (Adolescents) YES..... NO.....

Are you **pregnant**? YES..... NO..... WK#.....

Are you **nursing**? YES..... NO.....

## medical history

**Please provide explanation for any "yes" answers:**

Y or N **BLOOD DISORDERS** (prolonged bleeding, anemia, other)?.....

Y or N **CIRCULATORY PROBLEMS** (high blood pressure, heart murmur, antibiotic premedication, other)?.....

Y or N **IMMUNE PROBLEMS** (auto immune, diabetes, AIDS, other)?.....

Y or N **AIRWAY PROBLEMS** (mouth breathing, snoring, sleep apnea, asthma, tonsillectomy, other)?.....

Y or N **ALLERGIES** (latex, food, drug, nickel, other)?.....

Y or N **COMMUNICABLE DISEASE** (HIV, hepatitis, tuberculosis, other)?.....

Y or N **HISTORY OF TAKING** (Phen-Fen, Fosamax, or any other bisphosphonate)?.....

## dental history

**Please provide explanation for any "yes" answers:**

Y or N **Significant injury** to the teeth or jaws?.....

Y or N **Grind/clench** the teeth?.....

Y or N **Difficulty chewing**?.....

Y or N **Pain/clicking** in the jaw joints?.....

Y or N Treatment for a **TMJ disorder**?.....

## orthodontic history

**Please provide explanation for any "yes" answers:**

Y or N **Previous orthodontic treatment**?.....

Y or N **Concerns** about orthodontic treatment?.....

Y or N **Habits** related to the teeth (nail biting, finger habit, smoking, tobacco use, other)?.....

Y or N **Speech disorders/speech therapy**?.....

**SIGNATURE**.....**PRINT NAME**.....**DATE**.....

### For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herin. Initials:.....Date:.....

**Comments:**