Tardy ORTHODONTICS

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PATIENT INFORMATION

Welcome to our office! The following is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for us to thoroughly diagnose any condition, we must have accurate background and health information on which to base our decisions. This information, which is important for our records and your health, is confidential. Thank you.

Date _____

Patient's Name _____
Last First Middle Nickname Sex

Home Address _____ Zip _____ Home Phone _____

E-mail _____ Confirmation Phone _____ Cell Phone _____

Employer/School _____ DOB _____

Patient's Marital Status _____ Lives with: Mother Father Spouse Self Other: _____

Responsible Party Name _____ DOB _____ SSN# _____

Relationship _____ Employer _____ Phone (W) _____

Is Patient Covered by Insurance for Orthodontic Treatment? Yes No If Yes, Carrier _____ Group or Policy # _____

Emergency Contact if Patient unavailable _____ Phone _____

Family History: Is Father living? Yes No Health _____
Is Mother living? Yes No Health _____

Names and Birthdates of Brothers and Sisters: Sibling 1 Name _____ DOB _____
Sibling 2 Name _____ DOB _____
Sibling 3 Name _____ DOB _____

Hobbies or Special Interests _____

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

ORTHODONTIC HISTORY:

Has the patient had previous orthodontic consultation? Yes No Treatment? Yes No

Date: _____ Dr.: _____

Orthodontic Consultation was prompted by:
Patient Dentist Parent(s) Sibling Friend Other: _____

Patient's interest in treatment:
Wants Treatment Treatment if necessary Unwilling but agrees Uncooperative

Why did patient seek this consultation? _____

What is the primary problem? _____

What is expected from orthodontic treatment? _____

Doctor's Notes: _____

_____

_____

_____

MEDICAL HISTORY

Patient's Physician _____ City/State _____ Phone _____
Patient's Height _____ Patient's Weight _____ Adopted? Yes No
Has the patient ever had:

Asthma	Diabetes	Heart Disease	Hepatitis
Anemia	Epilepsy	Hearing Disorder	Rheumatic Fever
Blood Disorder/Hemophilia	Endocrine Problems	Head or Face Injury	Birth Defects
Bone Disorders	Emotional Problems	Herpes	Other (describe below)

Comments: _____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examination? Yes No
If yes, Condition: _____

_____

Is the patient currently taking any drugs or medication? Yes No
If yes, name(s): _____

Any allergies or reaction to any medication? _____

Has the patient reached puberty? Yes No

RESPIRATORY HISTORY

Does the patient:
1. Have allergies to: Seasonal grasses _____ Food(s) _____
   Drugs _____ Other: _____
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually
4. Have frequent colds? Yes No
5. Have frequent "stuffy nose" Yes No
6. Have frequent sore throat or tonsillitis? Yes No
7. Have chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from an allergist or ear, nose, throat specialist? Yes No

If yes, When _____ By whom _____
Nasal Surgery _____ Tonsils removed _____ Adenoids removed _____

DENTAL HISTORY

Patient's Dentist _____ City/State _____ Phone _____
Does the patient have pain or clicking in jaw joint? Yes No
Have any teeth been injured due to accidents or blows to the mouth? Yes No
Has the patient had or been advised to have speech correction? Yes No
Has the patient had (or does the patient now have) any of the following habits?
Thumb sucking _____ until age _____ Grinding of teeth _____ until age _____
Finger sucking _____ until age _____ Tongue thrusting _____ until age _____
Lip-biting or sucking _____ until age _____ Other Habits _____
Has the patient had any unusual dental experiences? Yes No Specify: _____
Date of last dental checkup _____ Were full-mouth or panoramic x-rays taken? _____
Patient Comments: _____

Our office provides payment plans based upon credit approval Your signature allows Tardy Orthodontics, P.C. to perform a credit history analysis This information will assist us in providing the best possible payment options

Signature _____ Date _____

Signature _____ Date _____