



**PATIENT INFORMATION - AGE 18 & Over**

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

Preferred Name \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Primary Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Employer/School \_\_\_\_\_

Primary Phone \_\_\_\_\_ Mobile Yes No Secondary Phone \_\_\_\_\_ Mobile Yes No

Hobbies and Interests \_\_\_\_\_

Whom may we thank for referring you to the office? \_\_\_\_\_

Responsible Party ( if different from patient): Responsible Party Phone # \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Relationship \_\_\_\_\_ DOB \_\_\_\_\_ SSN# \_\_\_\_\_

**Is Patient Covered by Insurance for Orthodontic Treatment? Yes No** Insurance Phone # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Is the Insurance provided through your employer? Yes No Employer \_\_\_\_\_

Is the responsible party listed above the policy holder? Yes No

If No, provide the Policy Holder information below: Policy Holder Phone # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_  
Last First Middle

Relationship \_\_\_\_\_ DOB \_\_\_\_\_ SSN# \_\_\_\_\_

Does the Policy Holder live at the same address as the patient? Yes No

If No, Policy Holder Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Comments: \_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Name (optional) \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

## 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 the patient seek this consultation? \_\_\_\_\_

What is the primary problem? \_\_\_\_\_

What is expected from orthodontic treatment? \_\_\_\_\_

## MEDICAL HISTORY

Patient's Physician \_\_\_\_\_

City/State \_\_\_\_\_

Phone \_\_\_\_\_

Patient's Height \_\_\_\_\_

Patient's Weight \_\_\_\_\_

Adopted? Yes No

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?** \_\_\_\_\_

### RESPIRATORY HISTORY

Does the patient:

Have allergies to seasonal grasses? \_\_\_\_\_ Food(s) \_\_\_\_\_

Drugs \_\_\_\_\_ Other: \_\_\_\_\_

Snore while sleeping? Yes No Breathe through mouth? Seldom Sometimes Usually

Have frequent colds? Yes No Have frequent "stuffy nose"? Yes No

Have frequent sore throat or tonsillitis? Yes No Have chewing or swallowing difficulty? Yes No

Received medical treatment from an allergist or ear, nose, throat, specialist? Yes No

If yes, what procedures were performed?

Nasal Surgery Date \_\_\_\_\_ Provider \_\_\_\_\_

Tonsils Removed Date \_\_\_\_\_ Provider \_\_\_\_\_

Adenoids Removed Date \_\_\_\_\_ Provider \_\_\_\_\_

### DENTAL HISTORY

Patient's Dentist \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Does the patient have pain or clicking in jaw joints? 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 \_\_\_\_\_  
\_\_\_\_\_

*I believe the above information is accurate and agree to inform this office of any changes in my medical or dental history. I will promptly notify the office of any changes in insurance coverage. In addition, I authorize the doctor(s) at Tardy Orthodontics, P.C. to perform a complete orthodontic evaluation.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_