TC Orthodontics

Name: _____ (M) (F) Nickname: _____Birthdate: __/___/____Age: ____

Address: _____ City: _____ St: _____ Zip:_____

Preferred Contact Information: Phone: _____ Email:_____

School: _____ Interests and Hobbies: _____

Names of Family Members in Treatment: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Who can we thank for referring you to our office? __Dentist __Website __Insurance __Friend/Neighbor_____

Primary concern: _____Have you ever had an orthodontic consultation? __Yes __No

RESPONSIBLE PARTY INFORMATION

Person Financially Responsible: _____

Relationship to patient: _____ Phone: _____

Address: _____City: _____St_____Zip: _____

PARENTAL INFORMATION IF PATIENT IS A CHILD

Fathers Name: _____

Employer: _____ Work Phone: _____

Mother's Name: _____

Employer: _____ Work Phone: _____

Are parents: Married_____ Divorced: _____ Separated: _____ Widowed: _____

INSURANCE:

Primary Policy Holder's Name: _____Birthdate: ___/___/___

Address: _____Employer: _____

Insurance Co:_____Address:_____

Group #: _____ ID #: _____Relationship to patient: _____

Secondary Policy Holder's Name: _____Birthdate: ___/___/___

Address: _____Employer: _____

Insurance Co:_____Address:_____

Group #: _____ ID #: _____Relationship to patient: _____

MEDICAL / DENTAL HISTORY

Dentists Name: _____ Address: _____

Date of Last Cleaning: ___/___ Any diagnosed dental needs yet to be treated? Yes No If yes, what? _____

Is patient under the care of a physician? ___Yes ___ No If Yes, for what reason? _____

List any medications that are currently being taken: _____

For what reason: _____

List any allergies to medications: _____

List any other allergies: _____

HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?

Heart Murmur	Yes No	Hepatitis	Yes No
Congenital Heart Defect	Yes No	AIDS/HIV	Yes No
Rheumatic Fever	Yes No	Tuberculosis	Yes No
Heart Disease	Yes No	Diabetes	Yes No
Abnormal Blood Pressure	Yes No	Cancer	Yes No
Seizures	Yes No	Blood Disorders	Yes No
Metal Allergy	Yes No	Other_____	
Bone Disorders	Yes No	If yes, are you taking Bisphosphonates?	Yes No

Does the patient have a latex allergy?	Yes No
Does the patient require antibiotic pre-medication before dental visits?	Yes No
Has the patient had any injuries involving the jaw or teeth?	Yes No
Does the patient have a persistent finger or thumb habit?	Yes No
Has the patient experiences any pain, locking or popping of the jaw?	Yes No
Has the patient ever been evaluated regarding a jaw problem?	Yes No
Does the patient grind or clench their teeth?	Yes No
Is the patient a mouth breather?	Yes No
Does the patient vomit, gag, or faint easily?	Yes No
Has the patient been treated for periodontal disease?	Yes No
Are you aware that some appointments may be made during school or work?	Yes No

Signature (Parent/Guardian if Patient is a Minor): _____Date: _____

Do we have your permission to communicate with you and your general dentist? ___ Yes ___ No

MEDICAL HISTORY UPDATE OR CHANGES

COMMENTS: _____

SIGNED: _____ DATE: _____ STAFF INITIALS: _____

COMMENTS: _____

SIGNED: _____ DATE: _____ STAFF INITIALS: _____

COMMENTS: _____

SIGNED: _____ DATE: _____ STAFF INITIALS: _____