Patient Information and Health History

Date ____________________

Patient Information

Name ____
FIRST MI LAST

Nickname ____

Sex ☐ **M** ☐ **F** Birthdate ________________________ Age ______

Home # ____________________ Cell # ____________________

Address ____

City ________________________ State _____ Zip ____________

Names of siblings (if patient is a minor)	Age	Received orthodontic care?
1.		☐ **Y** ☐ **N**
2.		☐ **Y** ☐ **N**
3.		☐ **Y** ☐ **N**

Dentist name ____

Last dental appt ____________________

Whom may we thank for referring you to our office?

____

School name ______________________________ Grade ______

Special interests: hobbies, sports, etc. ________________________

____

Would you like to ride on our FREE VIP School Shuttle? ☐ **Y** ☐ **N**
If yes, you will be asked to complete a VIP School Shuttle Form.

Parent Information (please complete if patient is a minor)

Father's Name ____
FIRST MI LAST

Address (if different) ____

City ________________________ State _____ Zip ____________

Home # ____________ Cell # ____________ Work # ____________

Email ______________________________ Birthdate ____________

Would you like text message appointment reminders? ☐ **Y** ☐ **N**
Would you like email appointment reminders? ☐ **Y** ☐ **N**
Are the parents, of the patient listed above, married? ☐ **Y** ☐ **N**

Person responsible for this account ______________________

Employer Information

Employer ____

Occupation ____

Insurance Company Name ____

Insurance Address ____

Insurance City ____________________ State _____ Zip ____________

Insurance Phone ____________________________ Ext ____________

Group # ____

Mother's Name ____
FIRST MI LAST

Address (if different) ____

City ________________________ State _____ Zip ____________

Home # ____________ Cell # ____________ Work # ____________

Email ______________________________ Birthdate ____________

Would you like text message appointment reminders? ☐ **Y** ☐ **N**
Would you like email appointment reminders? ☐ **Y** ☐ **N**

If divorce is involved, who is the custodial parent ______________
May patient information be released to
the non-custodial parent? ☐ **Y** ☐ **N**

Employer Information

Employer ____

Occupation ____

Insurance Company Name ____

Insurance Address ____

Insurance City ____________________ State _____ Zip ____________

Insurance Phone ____________________________ Ext ____________

Group # ____

Patient Name ____________________

Medical Information

YES	NO		YES	NO		YES	NO	
___	___	Is patient under medical care	___	___	Tonsils and/or adenoids removed	___	___	Osteoporosis
___	___	Is patient in good health	___	___	History of fainting or dizziness	___	___	Tumors or cancer
___	___	Heart disease	___	___	Unfavorable reaction to any medication	___	___	Radiation therapy
___	___	Is the patient pregnant	___	___	Nervous / Emotional problems	___	___	Cleft lip or palate
___	___	Kidney disease	___	___	Thyroid or hormonal imbalance	___	___	Speech problems
___	___	HIV / AIDS	___	___	High / Low blood pressure	___	___	Hearing problems
___	___	Bone Disorders	___	___	Heart murmur			
___	___	Epilepsy (Convulsions)	___	___	Heart valve problems			
___	___	Liver disease	___	___	Hepatitis			
___	___	Prolonged bleeding	___	___	Allergic to anything			
___	___	Prosthetic joint replacement	___	___	Tuberculosis			
___	___	Diabetes	___	___	Asthma or hay fever			
___	___	Anemia	___	___	Rheumatism or arthritis			

Please list any problems not mentioned that we should know about:

____

____

____

Please list any allergies:

____

____

____

List any medications the patient is currently taking:

____

____

____

Dental History

YES	NO		YES	NO	
___	___	Has the patient seen a general dentist in the last year	___	___	Clenching or grinding teeth
___	___	Has the mouth, face or teeth been injured by a fall or accident	___	___	Has the patient been examined by an othodontist in the past
___	___	Have you been informed of missing or extra permanent teeth	___	___	Are you happy about your teeth and smile
___	___	Are you aware of any "gum" problems	___	___	Any pain, clicking or discomfort in or near the ears (Jaw Joints)
___	___	Thumb or finger sucking (past age 5)	___	___	Frequent headaches
___	___	Mouth breathing	___	___	Any pain around the teeth, ears, temples or cheeks
___	___	Fingernail biting			

What would you like to improve about your teeth and smile? ____________________

How do you feel about wearing braces or Invisalign? ____________________

Any Questions for Dr. Curtis? ____________________

I understand that the information I have given on this form is accurate and that I am obligated to inform Dr. Curtis immediately if any Information changes in the future.

Signature of Patient or Parent/Guardian if patient is a minor ____________________ Date ____________

Emergency Contact

Name ____________________ Home # ____________ Cell # ____________

Address ____________________ City ____________ State ______ Zip ________