Patient Information and Health History

Date _____

Curtis ORTHODONTICS

215 W. Canfield Ave.
Coeur d'Alene, Idaho 83815
(208) 772-7272

602 N. Calgary Ct., Suite 302
Post Falls, Idaho 83854
(208) 777-0500

Patient Information

Name _____
FIRST MI LAST

Nickname _____

Sex ☐ **M** ☐ **F** Birthdate _____ Age _____

Home # _____ Cell # _____

Address _____

City _____ State _____ Zip _____

Email _____ @ _____

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

Would you like appointment reminders via: ☐ **text** ☐ **email**
Please provide us with the text number and/or email: (___) _____ _____ @ _____

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.

We love sharing photos of our patients in our office, website, Facebook, Instagram and blog. ***I prefer not to have my photo shared*** ☐

Dentist name _____

Last dental appt _____

Whom may we thank for referring you to our office?

_____

School name _____ Grade _____

Special interests: hobbies, sports, etc. _____

_____

Employer Information (Primary)

Subscriber's Name _____ DOB: _____

Employer _____

Occupation _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____ ID# _____

Employer Information (Secondary)

Subscriber's Name _____ DOB: _____

Employer _____

Occupation _____

Insurance Company Name _____

Insurance Address _____

Insurance City _____ State _____ Zip _____

Insurance Phone _____ Ext _____

Group # _____ ID# _____

Parent Information (please complete if patient is a minor)

Father's Name _____
FIRST MI LAST

Address (if different) _____

City _____ State _____ Zip _____

Cell/Home # _____ Work # _____

Email _____ Birthdate _____

Are the parents of the patient listed above married? ☐ **Y** ☐ **N**

Person financially responsible for this account _____

Mother's Name _____
FIRST MI LAST

Address (if different) _____

City _____ State _____ Zip _____

Cell/Home # _____ Work # _____

Email _____ Birthdate _____

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

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 orthodontist 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 smile? _____

Do you prefer: ☐ Metal Braces ☐ Clear Braces ☐ Invisalign

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. If dental insurance is present, I authorize Curtis Orthodontics to submit dental/orthodontic insurance claims for any and all services rendered at Curtis Orthodontics.

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

Emergency Contact

Name _____ Home # _____ Cell # _____

Address _____ City _____ State _____ Zip _____