CONFIDENTIAL PATIENT INFORMATION

Patient's Name ____
Address ____
Home Phone ______________D.O.B. ______________S.S.# ______________
If patient is a minor, give parent's or guardian's name ______________________
Whom may we thank for referring you to our office? ______________________

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION (*Required fields)

Name ______________________________* Marital Status ______________
Address ____ *
How long at this address? __________* Home Phone ______________* Work Phone ______________
Own ☐ Rent ☐ * Cell Phone ______________ E-Mail ______________
Previous address (if less than 3 years) ______________________________*
Social Security No. ______________* D.O.B. ______________ Relationship to patient ______________
Employer ______________* Occupation ______________* No. years employed _______*
Spouse's Name ______________________ Relationship to patient ______________
Employer ______________ Occupation ______________No. years employed_______
Social Security No. ______________ D.O.B. ______________ Work Phone ______________

INSURANCE INFORMATION

Primary Dental Insurance :
Policy Holder's Name ______________________ I.D.# ______________D.O.B ___________
Insurance Company ______________________ Group No. ______________________
Insurance Company Address ______________________ Phone No. ______________
Policy Holder's Employer ____
Secondary Dental Insurance:
Policy Holder's Name ______________________ I.D.# ______________D.O.B. ___________
Insurance Company ______________________ Group No. ______________________
Insurance Company Address ______________________ Phone No. ______________
Policy Holder's Employer ____

AUTHORIZATION and PRIVACY NOTICE

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
Furthermore, I acknowledge that I have been provided with a notice of privacy policies by Easton Orthodontic Associates.
I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent or Guardian's signature if minor) ______________________Date ___________

CONFIDENTIAL PATIENT INFORMATION

Patient Name ____________________________________I prefer to be called ____________________________
D. O. B. ______________________________ Age _______________________ Sex: Male ☐ Female ☐
If minor child, attends school at: _________________________ School District _________________________
Musical instruments played: ____
Sports/Hobbies ____
If minor child, please list any siblings name and age ____
Other family members treated here ____
What is your primary concern? Why are you here? ____
Is patient sensitive or self-conscious about teeth? ____
Who suggested that you or your child might need orthodontic treatment? _________________________________
Why did you select our office? ____
Name of Patient's Physician (s) ______________________________________Phone No. ____________________
Physician's Address ____
Date Last Seen Reason

MEDICAL HISTORY

Now or in the past, has the patient had:

☐ yes ☐ no Birth defects or hereditary problems?
☐ yes ☐ no Bone fracture, any major accidents?
☐ yes ☐ no Rheumatoid or arthritic conditions?
☐ yes ☐ no Endocrine or thyroid problems?
☐ yes ☐ no Kidney problems?
☐ yes ☐ no Diabetes?
☐ yes ☐ no Cancer, tumor, radiation treatment or chemotherapy?
☐ yes ☐ no Stomach ulcer?
☐ yes ☐ no Polio, mononucleosis, tuberculosis, pneumonia?
☐ yes ☐ no Problems of the immune system?
☐ yes ☐ no AIDS or HIV positive?
☐ yes ☐ no Hepatitis, jaundice or liver problem?
☐ yes ☐ no Fainting spells, seizures, epilepsy or neurological problem?
☐ yes ☐ no Mental health disturbance or depression?
☐ yes ☐ no Vision, hearing, tasting or speech difficulties?
☐ yes ☐ no Loss of weight recently, poor appetite?
☐ yes ☐ no History of eating disorder (anorexia, bulimia)?
☐ yes ☐ no Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐ yes ☐ no High or low blood pressure?
☐ yes ☐ no Cardiovascular problem (heart trouble, heart attack, angina, arteriosclerosis, stroke, heart murmur or rheumatic heart disease?
☐ yes ☐ no Eye, ear, nose or throat condition?
☐ yes ☐ no Hayfever, asthma, sinus, or hives?
☐ yes ☐ no Tonsil or adenoid conditions?

Allergies or reactions to any of the following:

☐ yes ☐ no Penicillin or other antibiotics
☐ yes ☐ no Latex (gloves, balloons)
☐ yes ☐ no Foods (specify) _____________________
☐ yes ☐ no Other substances (specify) _____________

☐ yes ☐ no Are you currently taking medication? Please name them.
Medication ___________ Taken for ______________
Medication ___________ Taken for ______________
Medication ___________ Taken for ______________

☐ yes ☐ no Does the patient need pre-medication for dental procedures?

☐ yes ☐ no Does the patient currently have or ever had a substance abuse problem?
☐ yes ☐ no Does the patient chew or smoke tobacco?
☐ yes ☐ no Surgeries? Describe _________________
____
☐ yes ☐ no Hospitalized? Describe _______________
____
☐ yes ☐ no Other physical problems or symptoms? Describe ___________________________________
____
☐ yes ☐ no Being treated by another health care professional? For ___________________________
Date of most recent physical exam? _______________
Are there any other medical conditions that we should be aware of? _____________________________

FEMALES ONLY WHEN APPLICABLE:

☐ yes ☐ no Has the patient started her monthly periods? If so, approximately when? _____________
☐ yes ☐ no Is the patient pregnant?

Patient Name ____
Name of Patient's Dentist ______________________ Phone No. ________________
Dentist's Address ____
Date Last Seen __________________ Reason ______________________________

DENTAL HISTORY

Now or in the past, has the patient had:

☐ yes ☐ no Started teething very early or late?
☐ yes ☐ no Primary (baby) teeth removed that were not loose?
☐ yes ☐ no Permanent or "extra" (supernumerary) teeth removed?
☐ yes ☐ no Supernumerary (extra) or congenitally missing teeth?
☐ yes ☐ no Chipped or otherwise injured primary (baby) or permanent teeth?
☐ yes ☐ no Teeth sensitive to hot or cold; teeth throb or ache?
☐ yes ☐ no Jaw fractures, cysts or mouth infections?
☐ yes ☐ no "Dead teeth" or root canals treated?
☐ yes ☐ no Bleeding gums, bad taste or mouth odor?
☐ yes ☐ no Periodontal "gum problems"?
☐ yes ☐ no Food impaction between teeth?
☐ yes ☐ no Thumb, finger, or sucking habit? Until what age? ______
☐ yes ☐ no Abnormal swallowing habit (tongue thrusting)?
☐ yes ☐ no History of speech problems?
☐ yes ☐ no Mouth breathing habit, snoring or difficulty in breathing?

☐ yes ☐ no Any pain in jaw or ringing in the ears?
☐ yes ☐ no Any pain or soreness in the muscles of the face or around the ears?
☐ yes ☐ no Difficulty encountered in chewing or jaw opening?
☐ yes ☐ no Aware of loose, broken or missing restorations (fillings)?
☐ yes ☐ no Any teeth irritating cheek, lip, tongue or palate?
☐ yes ☐ no Concerned about spaced, crooked or protruding teeth?
☐ yes ☐ no Aware or concerned about under or over developed jaw?
☐ yes ☐ no Any relative with similar tooth or jaw relationships?
☐ yes ☐ no Had periodontal (gum) treatment?
☐ yes ☐ no Any serious trouble associated with any previous dental treatment?
☐ yes ☐ no Ever had a prior orthodontic exam or treatment?
☐ yes ☐ no Been under another dental specialist's care? Specialist ______________________

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed: ________________________________ Date Signed __________________
(Parent or Guardian)
Signed: ________________________________ Date Signed __________________
(Dental Staff Member)

Medical History Update or Changes

Comments ____
____

Signed: ________________________________ Date Signed __________________
(Parent or Guardian)
Signed: ________________________________ Date Signed __________________
(Dental Staff Member)