PATIENT INFORMATION

First Name | Last Name | Nickname

Birthday | Age | Gender ○ Male ○ Female

Best Phone # | Contact E-Mail

Home Address

City | State | Zip code

Family Dentist | City | Dentist Phone

How do you prefer to receive appointment reminders? (Check all that apply) ☐ Phone ☐ Email

IF PATIENT IS AN ADULT – FILL OUT THIS SECTION

Employed by | Phone

Bus. Address

Spouse's Full Name | Employed by

IF PATIENT IS A CHILD – FILL OUT THIS SECTION

School | Grade

Father's Name | Mother's Name

Parents' Marital Status: ○ Single ○ Married ○ Divorced | Patient lives with

PRIMARY DENTAL INSURANCE

Ins. Company | Phone

Policy Holder | DOB | SSN/ID#

Employer

SECONDARY DENTAL INSURANCE

Ins. Company | Phone

Policy Holder | DOB | SSN/ID#

Employer

WHOM CAN WE THANK FOR YOUR REFERRAL?

○ Friend/Family Name ○ Google

○ Dentists Name/Office Name ○ Facebook/Instagram

○ Yelp ○ Other

ORTHODONTICS | LA
invisalign • braces

MEDICAL HISTORY

Please Choose Yes or No (If Yes, please provide details)

Yes ◯ **No** ◯ Are you taking medications? _____
Yes ◯ **No** ◯ Are you allergic to any medications? _____
Yes ◯ **No** ◯ Are you allergic to latex or nickel? _____
Yes ◯ **No** ◯ Do you have a history of a major illness? _____
Yes ◯ **No** ◯ Have you had any major operations? _____
Yes ◯ **No** ◯ Have you ever been involved in a serious accident? _____
Yes ◯ **No** ◯ Have you ever taken a bisphosphonate medication? (i.e. Fosamax, etc.) _____
Yes ◯ **No** ◯ Have you been advised to pre-medicate prior to dental appointments? _____

Choose any of the medical conditions below that you have had or currently have.

- ☐ Abnormal bleeding/ Hemophilia
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hay-fever
- ☐ Bone Disorders
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Gastrointestinal Disorders
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis/Liver problems
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV / Aids
- ☐ Joint Replacement
- ☐ Nervous Disorders
- ☐ Pneumonia
- ☐ Prolonged Bleeding
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

What concerns you most about your teeth?

_____

Yes ◯ **No** ◯ Are you presently in any dental pain?
Yes ◯ **No** ◯ Have you ever experienced any unfavorable reaction to dentistry?
Yes ◯ **No** ◯ Have you ever lost or chipped any teeth?
Yes ◯ **No** ◯ Have there been any injuries to face, mouth or teeth?
Yes ◯ **No** ◯ Do your gums bleed when you brush?
Yes ◯ **No** ◯ Do you have any type of thumb or tongue habit?
Yes ◯ **No** ◯ Are you a mouth breather?
Yes ◯ **No** ◯ Have you ever seen an orthodontist? If yes, who and when?
Yes ◯ **No** ◯ Has anyone in your family received orthodontic treatment?
Yes ◯ **No** ◯ Do your teeth or jaws ever feel uncomfortable when you wake up in the morning?
Yes ◯ **No** ◯ Are you aware of your jaw clicking or popping?
Yes ◯ **No** ◯ Are you aware of clenching your teeth during the day?
Yes ◯ **No** ◯ Have you ever been told that you grind your teeth?
Yes ◯ **No** ◯ Do you have “tension” headaches?

Female Patients only:

Yes ◯ **No** ◯ Are you pregnant?

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the doctors at Orthodontics LA to perform a complete orthodontic evaluation.

_____ _____
Patient/Guardian Signature Date

_____ _____
Doctors Signature Date