Date_____ Broken Arrow / Glenpool

PATIENT INFORMATION

Patient's Name_____ I prefer to be called_____ Sex____ Date of Birth_____
LAST FIRST MI

Patient's SSN_____ Age_____ School Attending _____ Dentist_____

How did you hear about our office? _____Did you see our Website or Yellowpage add? (Circle)

RESPONSIBLE PARTY INFORMATION

Cell #_____ Home # _____ Work # _____ Email _____ DOB _____

Name_____ Social Security #_____ Relationship to Patient_____
LAST FIRST MI

Mailing Address_____,_____,_____How long at this address? _____
STREET CITY STATE ZIP

Employer _____ Occupation_____ No. of Years Employed_____

Other Parent/Spouse's Name _____ Relationship to Patient _____
LAST FIRST MI

Employer _____ Occupation_____ No. of Years Employed_____

Social Security #_____ Date of Birth_____ Work Phone_____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name_____ Insured's SSN _____Insurance Company_____

Group No. _____ Insured's Employer _____If you have dual coverage, please list your other Insurance Company_____ Secondary Insured's Name_____

Secondary Insured's SSN_____ Employer _____ Group No. _____

MEDICAL/DENTAL HISTORY

Family History of (Circle All that apply) Underbite Overbite Neither Adopted? ☐ Yes ☐ No

Girls under 18: Has she started menstruation? ☐ Yes ☐ No **Boys under 18:** Has his voice changed? ☐ Yes ☐ No

Names and ages of Patient's Brothers _____Sisters _____

Family members previously in orthodontic treatment_____

Any major or unusual illnesses or other health problems? ☐ Yes ☐ No Explain_____

Currently under physician's care? ☐ Yes ☐ No Reason _____

Allergies? (Check those that apply) Aspirin_____ Nickel _____ Latex _____ Other _____

Drug sensitivity? Codeine_____ Penicillin _____ Erythromycin _____ Other_____

Has the patient ever taken premedication for a dental procedure due to a heart condition? _____

Please check if Patient Has or Had Any of the Following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Hepatitis	☐	☐	Heart Valve replacement	☐	☐	Jaundice (Besides at birth)
☐	☐	Blood Disease	☐	☐	Tuberculosis	☐	☐	Rheumatic fever	☐	☐	Epilepsy
☐	☐	Prolonged Bleeding	☐	☐	Diabetes	☐	☐	Malignancies, Tumors, or Cancer	☐	☐	Bone Disorders
☐	☐	AIDS or HIV positive	☐	☐	Asthma	☐	☐	Tonsils Removed: Age: _____	☐	☐	Endocrine Problems
☐	☐	Herpes	☐	☐	Mitral valve prolapsed with regurgitation	☐	☐	Adenoids Removed: Age:_____	☐	☐	Emotional Stress

☐ ☐ Has the patient had any severe head or face injuries? Explain_____

☐ ☐ Has the patient ever had a finger/thumb sucking habit? Is the habit still present? ☐ Yes ☐ No. Age habit stopped_____

☐ ☐ Does the patient play any musical instruments that involve the mouth? What? _____

☐ ☐ Has the patient consulted an orthodontist previously? Date _____ Doctor _____

☐ ☐ Has the patient had any previous orthodontic treatment? Explain? _____

PLEASE CHECK YES OR NO FOR THE FOLLOWING QUESTIONS

Yes	No		Yes	No		Yes	No	
☐	☐	Clenching Teeth	☐	☐	High Decay Rate	☐	☐	Jaw Joint Popping/Clicking
☐	☐	Grinding Teeth	☐	☐	Headaches (more than normal)	☐	☐	Ringing in the Ears
☐	☐	Muscular Soreness (head & neck)	☐	☐	Jaw Joint Soreness	☐	☐	Tongue Thrust
☐	☐	Snoring Loudly	☐	☐	Mouth Breather	☐	☐	Speech Problem/Speech Therapy

When was the patient's last visit with their dentist? _____

What do you or your dentist consider to be your main orthodontic problem?_____

_____

I hereby agree that all the above information is both accurate and current. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor)_____ Date _____