Beavercreek Orthodontics
Creating Classic Smiles

Date ________________ **Name** ________________________

ID No. ________________________

Confidential Patient Health History and Information Page 1

* Confidential Patient Information

Patient's Name: ________________________________ Gender: M F Patient's Nickname: __________
last first middle

Address: ________________________________ School/Grade if applicable:________________
street city state zip

Home Phone: ____________________ Birthdate: ____________________ *Social Security No.: ____________________

Guardian's name if minor: ________________________ Whom may we thank for referring you to our office?: ______________

* Confidential Responsible Party Information **Same as above** ☐

Name: ________________________________ *Marital Status: ____________________
last first middle

Billing Address: ________________________________ Social Security No.: ____________________
street city state zip

Birthdate: ________________ Relationship to Patient: ____________________ Direct Phone: ____________________

*Demographics of Responsible Party

Residence: ____
street city state zip

How long at the above address: ________________________ *Own: ____________ *Rent: __________

Home Phone: ____________________ Work Phone: ____________________Cell Phone: ____________________

Email: ________________________________ May we email or text an appt. reminder? __________

Previous Address (if less than 3 years): ____
street city state zip

Employer: ________________ Occupation: ____________ No. Years Employed: ________ Military Pay Grade: ________

Spouse's Name: ________________________________ Relationship to Patient: ____________
last first middle

* Insurance Information

Policy Holder's Name: ____________________________ D.O.B: __________ Social Security No.: ______________

Insurance Company: ________________________ Group No.: ______________ ID No.:____________________

Insurance Company Address:________________________ Insurance Co. Phone: ____________________

Policy Holder's Employer: ____

Do you have dual coverage?: Yes/No If yes, Policy Holder's Name: ________________________________

Social Security No.: ____________________ Insurance Company: ________________________________

Group No.: __________ ID No.: __________ Insurance Co. Address: ________________________________

Insurance Co. Phone: ____________________ Policy Holder's Employer: ________________________________

Emergency Contact Information

Name of Emergency Contact (not living with you): ________________________ Relationship: ____________

Address: ________________________________ Phone: ________________________
street city state zip

Patient / Parent / Legal Guardian understands that where appropriate, credit bureau reports may be obtained.

Signature: ____

Updates (date & initial): ____________________ *Dr.* ______ *Tech* ______

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Name ____________________

ID No. ____________________

Confidential Patient Health History and Information Page 2

Patient Dental History:

What is your main orthodontic problem(s)? ____________________

Are you sensitive about the appearance of your teeth or facial features (nose, chin, lips, etc)? ____________________

Are you interested in Traditional Braces? ____________________

Have you had an orthodontic consultation? Yes _____ No_____ If yes, when? ____________________

Has anyone in the family received orthodontic treatment from Beavercreek Orthodontics? Yes ______ No _______

If yes, who? ____________________

Name of your current general dentist: ____________________ How many years?__________

Name of previous general dentist: ____________________

Frequency of dental checkups? ____________________ Date of last dental exam: ____________________

Is there any pending dental care? Yes _____ No _____

Date pending care completed? ____________________

General Dental:

Please check any of the following that apply and explain in the box below:

- ❍ Are you apprehensive about dental care?
- ❍ Have you had any trouble associated with dental treatment?
- ❍ Have you had any teeth extracted?
- ❍ Have you ever injured or broken any teeth?
- ❍ Do you have any discomfort from teeth?
- ❍ Do you have any missing teeth?
- ❍ Have you been referred or are you being treated by a dental specialist?
- ❍ Do you suck on your fingers or thumb?
- ❍ Do you have any trouble eating, chewing or swallowing?
- ❍ Do you have any extra teeth?
- ❍ Do you receive regular fluoride treatment?
- ❍ Do you have discomfort from gums?
- ❍ Do you breathe with your mouth open or lips parted?

If you have checked any of the above, please explain:

Facial / Jaw History:

Please check any of the following that apply and explain in the box below:

SECTION ONE

- ❍ 1. Do you have limited jaw movement?
- ❍ 2. Do your jaws click or pop?
- ❍ 3. Do you have frequent canker sores?
- ❍ 4. Are you aware of any swellings or growths in your mouth?
- ❍ 5. Have you had any injuries to your facial / jaw?

If you have checked any of the above, please explain:

SECTION TWO

- ❍ 6. Do you grind or clench teeth?
- ❍ 7. Do you have regular jaw pain?
- ❍ 8. Have you ever had a Headache?
- ❍ 9. Have you ever had Botox / Xeomin / Dermal Fillers?
- ❍ 10. Are you interested in Botox / Xeomin / Dermal Fillers to improve esthetics or help with Headache / Jaw Pain?

If you have checked any of the above, please explain:

Dr. ______ Tech ________

Name ______________________

ID No. ______________________

Confidential Patient Health History and Information Page 3

Patient Medical History Information

Name & Location of Physician: ____ Are you in good health: ________

Date of last physical: _________ Are you presently under the care of a physician for any illness? _______________ Please specify below.

Do you have a history of major illness or been hospitalized? ____________________________________ Please specify below.

Is there anything you would like to talk to the doctor about in private? ____________________________________

Please check any of the following that apply to the patient and explain in the box below:

- ❍ Have you seen a medical specialist?
- ❍ Do you have a tendency to catch colds?
- ❍ Do you have an allergy to latex?
- ❍ Do you have an allergy to metals?
- ❍ Do you have any drug allergies/sensitivities?
- ❍ Do you require pre-medications?
- ❍ Are you taking any drugs or medications?
- ❍ Have you ever received Bisphosphonate treatment or other bone building medications? *(e.g. Fosamax, Actinol, Boniva)*
- ❍ Do you have gastric reflux?
- ❍ Are you pregnant or breast feeding?
- ❍ Are you taking any anti-inflammatory or blood thinning medications.
- ❍ Do you take Retin-A?

Please check any of the following for which the patient has been treated and explain in the box below:

- ❍ AIDS/HIV
- ❍ Asthma
- ❍ Arthritis
- ❍ Artificial joints
- ❍ Bone disorders
- ❍ Cancer
- ❍ Cerebral palsy
- ❍ Diabetes
- ❍ Emotional problems
- ❍ Endocrine problems
- ❍ Fainting or dizziness
- ❍ Frequent headaches or neck aches
- ❍ Heart trouble *(i.e. congenital heart defect, murmurs)*
- ❍ Hepatitis
- ❍ Hormone therapy
- ❍ Jaundice
- ❍ Kidney problems
- ❍ Liver problems
- ❍ Low/high blood pressure
- ❍ Multiple sclerosis
- ❍ Nervous disorders
- ❍ Osteoporosis
- ❍ Prolonged bleeding
- ❍ Rheumatic Fever
- ❍ Sickle cell anemia
- ❍ Sleep Apnea/Snoring
- ❍ Stomach ulcers
- ❍ Tuberculosis
- ❍ Thyroid problems
- ❍ Unusual growth patterns

If you have checked any of the above, please explain:

I authorize the release of any necessary dental or medical records to Beavercreek Orthodontics for this patient. Records may be discussed with other health care providers and/or for educational purposes.

____
Responsible Person

Dr. ______ *Tech* ________