Aligned
FAMILY ORTHODONTICS

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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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:

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ID No. _____

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