Patient Information

Date: _____

Patient's name_____

Last First Middle

Address_____

Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

DOB_____ Social Security #_____ Email Address: _____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security #_____Birthdate_____Work Phone_____

Dental Insurance Information

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes: Insured's Birthdate _____

Insured's Name_____ Insured's Social Security #_____

Insurance Company_____ Group No._____

Insurance Co. Address_____ Phone No._____

MEDICAL & DENTAL HISTORY

Physician_____ Date of Last Visit_____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
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…)_____

deroode orthodontics

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

Abnormal bleeding/Hemophilia Diabetes Hepatitis/Liver problems Pneumonia

Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

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

_____

Dentist_____ Date of last visit_____

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 Is any part of your mouth sensitive to temperature or pressure?_____

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 awake 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?

_____

Yes No Have you ever experienced chronic ringing in your ears?

_____

Female Patients only:

Yes No Are you pregnant?

_____

Yes No If under age 15, has menstruation started? If so, at what age? _____

I understand that my diagnostic records (photos/x-rays) may be used for educational and/or promotional purposes. 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 Dr. deRoode to perform a complete orthodontic evaluation.

Signature:_____Date:_____

(Parent of Guardian if patient is a minor)

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