torres ORTHODONTICS

Member American Association of Orthodontists®

Today's date _____/_____/_____

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Patient's name _____ Age_____

Nickname_____ Sex M / F Birthdate _____/_____/_____

Address _____ City _____ST _____ Zip _____

Home ph. #_____ Work ph.#_____

If patient is a minor, give parent's/guardian's name _____

Hobbies/interests _____ School/Occupation _____ Grade _____

Sisters/Brothers or Daughters/Sons (names/ages) _____

Close friend or relative who is a patient here _____

Has the patient had a previous orthodontic consultation? Y / N Previous orthodontic treatment? Y / N

If so, when/where? _____ Dr.'s name_____

What is it about your teeth/bite and/or appearance that has brought you to see us? _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ Relat. to Pt. _____ Marital Status S / M / W / D

Mailing Address _____ City _____ ST _____Zip _____

Home ph. # _____ Work # _____ Mobile # _____

Employer _____ Occupation _____ No. yrs. emp'd. _____

Social Security #_____- ____ - _____ Birthdate_____ /_____/_____ Drivers License #_____

Email address_____

Spouse's name _____ Relat. to pat._____

Employer _____ Occupation _____ No. yrs. emp'd. _____

INSURED INFORMATION

Name of Insured_____ Relat. to Pt_____

Insurance Company Name _____ Telephone #_____

Employer _____ Occupation _____ No. yrs.emp'd. _____

Social Security #_____- ____ - _____ Birthdate_____ /_____/_____ Drivers License #_____

DENTAL HISTORY

How does the patient feel about wearing "braces"? _____

Does anyone else in the family have a similar orthodontic problem? Y / N Who? _____

Patient's dentist _____ Does the patient receive regular dental checkups? Y / N

Last dental exam _____ Last dental X-rays _____

Other dental specialists _____

Is patient satisfied with past dentistry? Y / N Any unfavorable dental experiences? _____

Does the patient currently have, or has the patient ever had any of the following? (Please circle)

Thumb/finger habit	Head/neck injury
Nail biting	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about? _____

MEDICAL HISTORY

Patient's Physician _____ Patient's overall health status? Excellent / Good / Poor

Is the patient allergic to anything (drugs, food, pollen)?_____

Is the patient presently under medical care? Y / N For what/where?_____

Is the patient currently taking any medications? _____

Has the patient ever been hospitalized? Y / N When/ Where?_____

Does the patient currently have, or has the patient ever had any of the following? (Please circle)

Adenoids removed	Drug addiction	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal/airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal disease

Is there any other medical information that we should know about?

_____

Signature _____

Patient's/Parent's signature to verify above information

Updates (dates & initials) _____ _____ _____ _____