eppard ORTHODONTICS

PATIENT INFORMATION

Today's Date _____

Patient's Name _____ Prefers to be called _____

Address _____

City _____ State _____ ZIP _____

Home Phone _____ Birthdate _____ Age _____ Sex _____

Cell Phone _____ Email _____

☐ I would like to receive email appointment reminders

School Name _____ Grade _____

Family Dentist _____ Date of last visit _____

Hobbies _____

What would you like orthodontic treatment to accomplish? _____

Which are you most interested in? ☐ Invisalign® ☐ Clear Braces ☐ Metal Braces

Whom may we thank for referring the patient to Eppard Orthodontics? _____

Responsible Party _____ Birthdate _____ Wk. Ph. _____

Occupation _____ Employer _____

Cell Phone _____ Email _____

☐ I would like to receive email appointment reminders

Spouse/Other _____ Birthdate _____ Wk. Ph. _____

Occupation _____ Employer _____

Cell Phone _____ Email _____

If divorce is involved, who is the Custodial Parent? _____

May the patient information be released to the Noncustodial Parent? ☐ **NO** ☐ **YES**

Non-Custodial Parent's Address _____

City _____ State _____ ZIP _____

Brothers and Sisters: Previously treated here? ☐ Yes ☐ No

Name _____ Birthdate _____ Name _____ Birthdate _____

Name _____ Birthdate _____ Name _____ Birthdate _____

Insurance

Primary Dental Insurance Orthodontic Coverage? ☐ Yes ☐ No

Insured's Name _____ Relationship to Patient _____

Employer _____ Insurance Company _____

Date of Birth _____ ID/SS# _____ Insurance Phone # _____

Secondary Dental Insurance Orthodontic Coverage ☐ Yes ☐ No

Insured's Name _____ Relationship to Patient _____

Employer _____ Insurance Company _____

Date of Birth _____ ID/SS# _____ Insurance Phone # _____

Signature of Parent/Patient/Guardian _____ Date _____

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MEDICAL/DENTAL HISTORY

Dentist's Name _____ Phone _____ Date of last visit _____
Does the patient have dental work that needs to be completed? ☐ Yes ☐ No Please Describe _____
Physician's Name _____ Phone _____ Date of last visit _____
Is the patient under the care of a physician for a specific problem at this time? ☐ Yes ☐ No
If yes, for what reason?_____
Are you taking any prescription medication? ☐ Yes ☐ No
If yes, please list _____
Are you currently taking a biphosphonate for osteoporosis? ☐ Yes ☐ No
Does the patient have any allergies ☐ Yes ☐ No
If yes, please list _____
Has there ever been an adverse reaction to latex or nickel? ☐ Yes ☐ No Please describe_____
Does the patient need antibiotics before seeing the dentist? ☐ Yes ☐ No
Has an orthodontist previously been consulted? ☐ Yes ☐ No If yes, when _____
Have you had previous orthodontic treatment? ☐ Yes ☐ No
What brings you to our office? _____

Does the patient have or has had any of the following medical conditions? Check all that apply

- ☐ Milk Allergy
- ☐ Heart problems
- ☐ Glaucoma
- ☐ Asthma/Hay fever
- ☐ Eye problems/wears contacts
- ☐ Frequent headaches
- ☐ Endocrine disorder
- ☐ Easy bruising
- ☐ Osteoporosis
- ☐ Sleep Apnea
- ☐ Jaw/Facial Injuries
- ☐ Thumb/finger habit
- ☐ Rheumatic or Scarlet Fever
- ☐ Diabetes
- ☐ Inflammatory Rheumatism
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Dizziness or fainting
- ☐ Sinus problems
- ☐ STD
- ☐ Tongue thrusting
- ☐ Clenching / Grinding of Teeth
- ☐ Dental/Tooth Injuries
- ☐ Gum Disease (Bleeding Gums)
- ☐ Neurological disorders
- ☐ Anemia
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Epilepsy or seizures
- ☐ Bleeding disorders/Anemia
- ☐ HIV positive
- ☐ Speech problems
- ☐ Jaw Locking
- ☐ Tooth Pain
- ☐ Other illness _____
- ☐ Congenital Heart Defect
- ☐ Arthritis, swollen joints
- ☐ Autism/Aspergers
- ☐ Hepatitis type ___
- ☐ Low blood pressure
- ☐ Smoke/Chew Tobacco
- ☐ Mental Disorder/Depression
- ☐ ADD/ADHD
- ☐ Mouth breathing
- ☐ Sore Facial Muscles
- ☐ Pregnant / Nursing

For Adolescent Patients

Have the tonsils and adenoids been removed? ☐ Yes ☐ No If yes, when? _____
Has the patient reached puberty? ☐ Yes ☐ No
If female, has she started menstruation? ☐ Yes ☐ No If yes, month/year _____
Have you been informed of any missing/extra teeth? ☐ Yes ☐ No

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

Signature of Patient/Parent/Guardian _____ **Date** _____

OFFICE USE ONLY

I verbally reveiwed the medical/dental information above with the Patient/Parent/Guardian
Signature _____ Date _____

WELCOME TO

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ORTHODONTICS

HELP US GET TO KNOW MORE ABOUT YOU!

My Name Is _____

But you may call me _____

My school is _____

I like to play _____

My favorite TV show is _____

My favorite book is_____

I really love to _____

I have a pet _____ **And I call it** _____

My favorite place to go is _____

My favorite song or band is _____

My hobbies are _____

I am really good at _____

I wish I could _____

My friends _____**come here for braces too!**