MINARS ORTHODONTICS

PATIENT INFORMATION

LAST NAME	FIRST NAME	SS #	SEX	BIRTHDATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	PHONE #

NAME OF GENERAL DENTIST	DATE OF LAST VISIT	SCHOOL (if student)	GRADE

[ ]married [ ]single [ ] sep [ ] Divorced [ ] Widow(er)	EMPLOYED BY/ OCCUPATION	**EMAIL** ADDRESS FOR APPOITMENTS CONFIRMATION

BUSINESS PHONE #	WHO REFERRED YOU OR HOW DID YOU HEAR ABOUT

RELATED PATIENTS THAT HAVE BEEN UNDER OUR CARE	NAMES AND AGES OF OTHER CHILDREN

PARENT/SPOUSE INFORMATION

PLEASE FILL OUT FULLY

SPOUSE OR FATHER'S NAME	SPOUSE OR MOTHER'S NAME
_____	_____
ADDRESS (if different than patient's)	ADDRESS (if different than patient's)
CITY_____ STATE_____	CITY_____ STATE_____
ZIP_____ **SS#**_____	ZIP_____ **SS#**_____
HOME PH #_____WORK PH #_____	HOME PH #_____WORK PH #_____
EMPLOYER_____	EMPLOYER_____
ADDRESS_____	ADDRESS_____
CITY_____STATE_____ZIP_____	CITY_____STATE_____ZIP_____
BIRTH DATE_____	BIRTH DATE _____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME	**RELATIONSHIP TO PATIENT**	**EMPLOYED BY/ OCCUPATION**	

MAILING ADDRESS	CITY	STATE	ZIP	PHONE_____ BUS PHONE_____

IF DIVORCED, WHO IS THE CUSTODIAL PARENT?	MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? YES_____ NO___

MEDICAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAD

[Y] [N]

[ ] [ ] Handicap/disabilities
[ ] [ ] Joint swelling
[ ] [ ] Heart trouble/heart murmur
[ ] [ ] Mitral valve prolapse
[ ] [ ] Rheumatic trouble
[ ] [ ] Thyroid problems
[ ] [ ] Diabetes
[ ] [ ] Emotional problems
[ ] [ ] Brain injury
[ ] [ ] Kidney or liver involvement
[ ] [ ] Joint prosthesis
[ ] [ ] Tuberculosis
[ ] [ ] Anemia
[ ] [ ] Epilepsy
[ ] [ ] Prolonged bleeding
[ ] [ ] Faintness/dizziness
[ ] [ ] Tonsils removed
[ ] [ ] Adenoids removed
[ ] [ ] Sore throats or earaches
[ ] [ ] Tonsilitis
[ ] [ ] Taken PhenFen
[ ] [ ] High or low blood pressure (circle)

Has any member of the family or close relative had:

[ ] [ ] Rheumatoid arthritis
[ ] [ ] Lupus

List any other serious illnesses:

List any allergies: (to: latex, acrylic, medications, reaction to jewelry, nickel, etc.)

List drugs or medications now being taken:

Name of physician?

Is patient presently under physicians care?
Yes [ ] No [ ]
Reason:

DENTAL HISTORY

PLEASE CHECK YES OR NO

[Y] [N]

[ ] [ ] Does the patient play a musical instrument?
[ ] [ ] Any injuries to face or teeth? (circle)
[ ] [ ] Thumb, finger, lip sucking? (circle)
[ ] [ ] More than average amount of decay?
[ ] [ ] Any missing permanent teeth?
[ ] [ ] Any extra permanent teeth?
[ ] [ ] Any teeth removed by extraction?
[ ] [ ] Any difficulty in swallowing or chewing?
[ ] [ ] Any pain or clicking when opening your mouth?
[ ] [ ] Has patient been told that they have TMD?
[ ] [ ] Is patient adopted? At what age_____
[ ] [ ] Does patient visit dentist regularly?
Date of last visit_____
[ ] [ ] Does patient clench or grind teeth?
[ ] [ ] Does patient bite fingernails
[ ] [ ] Does patient thrust their tongue?
[ ] [ ] Does patient have speech problems?
[ ] [ ] Has an orthodontist been consulted previously?

Reason for consultation:

Approximately how much has patient grown in the last year?

What about your teeth or face bother you?

What would you like orthodontic treatment to accomplish?

Adolescent females: Has menstruation begun?
[ ] Yes [ ] No
Date (month/year) _____

Females: Are you pregnant? [ ] Yes [ ] No
How many months? _____

Patient's attitude toward orthodontic treatment?
(circle one) Very motivated / Will cooperate if needed / Not motivated

To the best of my knowledge, the above information is complete and correct.

PRIMARY ORTHODONTIC COVERAGE

ORTHODONTIC COVERAGE: YES NO

INSURANCE COMPANY NAME: _____ PHONE # ( ) _____

INSURANCE COMPANY ADDRESS:_____

POLICY HOLDER'S NAME:_____ BIRTHDAY:_____ SS#:_____

GROUP#_____

RELATIONSHIP TO PATIENT: _____

_____ _____ _____

Print Name **Signature of Patient/Parent/Guardian** **Date**