20 MILE ORTHODONTICS

WELCOME TO OUR OFFICE!

PATIENT INFORMATION

PATIENT'S NAME:_____DATE:_____

ADDRESS:_____SEX_____
CITY ZIP

HOME PHONE#:_____ D.O.B._____AGE:_____

SCHOOL:_____

HOW DID YOU HEAR OF OUR OFFICE:_____

NAME OF DENTIST OR DENTAL PRACTICE:_____

FATHER

NAME:_____

ADDRESS:_____

CELL PHONE#_____

E-MAIL:_____

EMPLOYER:_____

WORK PHONE:_____

MOTHER

NAME:_____

ADDRESS:_____

CELL PHONE#_____

E-MAIL:_____

EMPLOYER:_____

WORK PHONE:_____

INSURANCE INFORMATION

INSURED'S NAME:_____D.OB._____ SOC. SEC.#_____

INSURANCE CO.:_____GROUP#_____PHONE#_____

ADDRESS:_____

DO YOU HAVE DUAL INSURANCE? YES NO IF YES PLEASE CONTINUE

INSURED'S NAME:_____D.O.B._____SOC. SEC. #_____

INSURANCE CO.:_____GROUP#_____PHONE#_____

ADDRESS:_____

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:_____

ADDRESS:_____

PHONE:_____RELATIONSHIP TO PATIENT_____

MEDICAL HISTORY

PLEASE EXPLAIN

IS PATIENT CURRENTLY UNDER A PHYSICIAN'S CARE? Y N _____

IS PATIENT CURRENTLY TAKING ANY MEDICATION? Y N _____

DOES THE PATIENT HAVE ANY GENERAL ALLERGIES Y N _____

ANY SPECIFIC DRUG SENSITIVITY OR ALLERGIES? Y N _____

IS PATIENT PREGNANT? Y N _____

PLEASE CIRCLE IF THE PATIENT HAS OR HAD ANY OF THE FOLLOWING.

HEART MURMUR	Y	N	PROLONGED BLEEDING DISORDER	Y	N
BLOOD DISEASE	Y	N	RHEUMATIC FEVER	Y	N
DIABETES	Y	N	ENDOCRINE PROBLEMS	Y	N
HEPATITIS	Y	N	EPILEPSY/SEIZURE DISORDER	Y	N
HERPES	Y	N	ADENOID OR SINUS INFECTIONS	Y	N
TUBERCULOSIS	Y	N	TONSILLITIS	Y	N
ASTHMA	Y	N	TONSILS REMOVED AT AGE? _____		
CANCER	Y	N	KIDNEY/LIVER DISORDER	Y	N
AIDS/HIV	Y	N	HANDICAPS/DISABILLITIES	Y	N

PLEASE INCLUDE ANY ADDITIONAL MEDICAL CONCERNS THAT YOU MAY HAVE.

_____

_____

DENTAL HISTORY

HAS THE PATIENT HAD ANY SEVERE JAW OR FACIAL INJURIES?_____

HAS THE PATIENT HAD ANY INJURIES TO TEETH?_____

PLEASE CIRCLE IF THE PATIENT HAS ANY HISTORY OF THE FOLLOWING.

THUMB SUCKING	Y	N	CLENCHING/GRINDING TEETH	Y	N
JAW SORENESS	Y	N	EXCESSIVE HEADACHES	Y	N
TONGUE THRUST	Y	N	SORENESS AROUND HEAD/NECK	Y	N
JAW POPPING/CLICKING	Y	N			

PLEASE INCLUDE ANY ADDITIONAL DENTAL CONCERNS THAT YOU MAY HAVE.

_____

WHAT ARE THE MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ACCOMPLISH?

_____

SIGNATURE_____DATE_____