Patient Information

Patient Name____ Male Female
Last First Middle

Address____
Street City State Zip

Home Phone__________________Birthdate____________________email______________________________

If patient is a minor, give legal guardian's name(s)____

Siblings and ages____

Whom may we thank for referring you to our office? Dentist____________________ Friend/Family______________

Patient of our office______________________ Advertisement: ☐ Radio ☐ Yellow Pages ☐ Newspaper ☐ Other ________

Orthodontic Insurance Information

Do you have: ☐ Insurance ☐ Orthodontic Benefit *(i.e. Mayo Benefit)* ☐ Flex Plan ☐ None

Policy Holder's Name ____________________________ Social Security #___________ Birthdate ____________

Insurance Company Name ____________________________and Address______________________________

Insurance Group Number______________________________ Subscriber ID ______________________________

Responsible Party Information

Name____Marital Status____________
Last First Middle

Residence____
Street City State Zip

How Long at this address_____________ Home Phone____________________ Work Phone________________

Previous Address *(if less than 3 years)*____
Street City State Zip

Email Address *(for appointment reminders)* ____

Birthdate__________________________ Relationship to Patient__________________________

Employer__________________________Occupation____________________No. Years Employed_________

Spouse's Name____Relationship to Patient____________
Last First Middle

Employer__________________________Occupation____________________No. Years Employed_________

Birthdate__________________________ Work Phone__________________________________

Patient Medical History

1. Is the patient in good general health at this time?	☐ Yes	☐ No
2. Is the patient under the care of a physician at this time?	☐ Yes	☐ No
3. Is the patient taking any medication(s)?	☐ Yes	☐ No
4. Is the patient allergic to any medications?	☐ Yes	☐ No
5. Has the patient had tonsils and adenoids removed?	☐ Yes	☐ No
6. Has the patient ever had serious injuries or been hospitalized?	☐ Yes	☐ No
7. Does the patient have any special problems not listed?	☐ Yes	☐ No
8. Has the patient ever been advised by a physician to take an antibiotic prior to any dental work?	☐ Yes	☐ No
Please discuss any items answered yes:	☐ Yes	☐ No

Today's Date ______________________________

OFFICE USE ONLY:

A B C + – Prior + –

Patient Dental History

Patient's Dentist____Date of Last Visit_________________________

Have there been any injuries to the face, mouth or teeth?	☐ Yes	☐ No
If Yes, please explain____		
Has the patient had (past or present) any of the following habits:		
Thumb or finger sucking	☐ Yes	☐ No
Grinding of teeth at night	☐ Yes	☐ No
Lip Biting	☐ Yes	☐ No
Mouth Breathing	☐ Yes	☐ No
Has an Orthodontist been consulted previously for this patient?	☐ Yes	☐ No
Has there been orthodontic treatment for other family members?	☐ Yes	☐ No
If Yes, treated by Dr. ________________________________		
Has the patient ever been treated for:		
TMJ	☐ Yes	☐ No
"Bad Bite"	☐ Yes	☐ No
Periodontal Gum Disease	☐ Yes	☐ No
Does the patient have any speech problems?	☐ Yes	☐ No
Is the patient concerned or anxious about orthodontic treatment?	☐ Yes	☐ No

Please explain any concerns about the appearance of the teeth and anything you would like to change about the smile:

____

Has the Patient ever had any of the Following?

Yes	No		Yes	No	
☐	☐	Congenital Heart Defect	☐	☐	Inflammatory Rheumatism
☐	☐	Heart Disease	☐	☐	Arthritis
☐	☐	Hearing Impairment	☐	☐	Diabetes
☐	☐	Heart Murmur	☐	☐	Ulcers
☐	☐	Rheumatic Fever	☐	☐	Stroke
☐	☐	Prosthetic (Artificial) Joint	☐	☐	Anemia
☐	☐	Radiation Therapy	☐	☐	Asthma
☐	☐	Respiratory/Lung Disease	☐	☐	Epilepsy
☐	☐	High Blood Pressure	☐	☐	Glaucoma
☐	☐	Low Blood Pressure	☐	☐	Fainting Spells
☐	☐	Hepatitis	☐	☐	Kidney Trouble
☐	☐	Tuberculosis	☐	☐	Liver Disease
☐	☐	Aids or H.I.V. Positive	☐	☐	Psychiatric Treatment
☐	☐	Venereal Disease	☐	☐	Drug Addiction
☐	☐	Herpes (oral cold-sores)	☐	☐	Headaches
☐	☐	Blood Disorders	☐	☐	Earaches
☐	☐	Jaw Clicking	☐	☐	Allergies
☐	☐	Jaw Pain	☐	☐	Tonsillitis
☐	☐	Emotional Issues	☐	☐	Other

Bisphosphonates

Yes	No
☐	☐

Are you currently taking OR have you *ever* taken a Bisphosphonate medication, commonly used for Osteoperosis and other conditions that feature bone fragility?

Bisphosphonates are sometimes marketed as Boniva, Fosamax, Fosamax+D, Actonel, Reclast, Actonel+Ca, Aredia, Didronel, Skelid, and Zometa.

If yes, when did you begin the medication? _______________

When did you end the medication? _______________

PLEASE DISCUSS ANY ITEMS ANSWERED YES:____

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Acknowledgement

Benefits of Orthodontics include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay, decalcification, and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I understand that my diagnostic records and my name may be used for educational purposes. I also understand that orthodontic appointments are often during work and/or school hours. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. Overby Orthodontics will not be held responsible for any problems arising out of inadequate or undisclosed information. In addition, I authorize Drs. Overby and/or Finnegan to perform a complete orthodontic evaluation.

____ ______________________________

Signature of Patient or Patient's Legal Guardian, if a minor Date