Northshore ORTHODONTICS

Date_____

Personal Information

Patient's full name_____ Nickname (if preferred) _____

Birthdate(d/m/y) _____ Age_____ Gender_____

Address_____
Street City Postal Code

Phone_____ Cell_____

Employer_____ Email_____

Person responsible for account _____ Contact info if different from above _____

_____

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

Do you carry orthodontic insurance? _____ If yes (Insurance Carrier) _____

Insurance Policy holder: (name)_____(birthdate d/m/y)_____

Insurance Policy numbers: _____ _____

Family members treated in office_____

Hobbies/Activities _____

Medical History

Physician_____ Date of Last Visit_____

Please Indicate Yes or No (If Yes, please fill in details)

_____Abnormal Bleeding
_____ADD/ADHD
_____Allergies (latex, metals, plastic, meds, etc.)
_____Anemia
_____ Any hospital stays
_____Any Operations_____
_____Arthritis
_____ Autism Spectrum
_____Asthma / Hay Fever
_____Blood Transfusion
_____Bone Disorders
_____Cancer or Tumor
_____Congenital Heart Defects
_____Convulsions / Epilepsy
_____Diabetes
_____ Dizziness / Fainting
_____Emotional Problems
_____Gastrointestinal Disorders
_____Handicaps / Disability
_____Hearing Impairment
_____Heart Attack / Stroke
_____ Heart Murmur
_____Heart Surgery
_____Hepatitis / Liver Problems
_____Herpes / Fever Blisters
_____ High Blood Pressure
_____HIV+ / AIDS
_____ Kidney Problems
_____Lupus
_____Mitral Valve Prolapse
_____ Nervous / Psychiatric Disorder
_____ Pneumonia
_____Radiation / Chemotherapy
_____Rheumatic / Scarlet Fever
_____Shingles
_____Sickle Cell Disease
_____Sinus Problems
_____Tuberculosis (TB)
_____Venereal Disease

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

Please list all medications you are currently taking? _____
_____

Yes or No Are you currently under the care of a physician?_____

Dental History

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

_____

Yes	No	
☐	☐	Are you presently in any dental pain? _____
☐	☐	Have you ever experienced any unfavorable reaction to dentistry? _____
☐	☐	Have you ever lost or chipped any teeth? _____
☐	☐	Have you ever had any injuries to face, mouth, or teeth? _____
☐	☐	Did you ever have any type of thumb or finger habit? _____
☐	☐	Do you have any type of tongue habit or speech problems? _____
☐	☐	Are you a mouth breather? _____
☐	☐	Do you grind or clench his/her teeth? _____
☐	☐	Do you experience jaw clicking, popping, locking, or pain? _____
☐	☐	Do you experience frequent headaches? _____
☐	☐	Are you sensitive or self-conscious about his/her teeth? _____
☐	☐	Have you ever seen an orthodontist? If yes, who and when? _____
☐	☐	Has anyone in the family received orthodontic treatment? _____

Benefits

Benefits of Orthodontics: 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 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 have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Millar to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

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