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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