Patient Information

Date____________________

Name____ Date of birth________________
Last First Middle

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Home Phone_______________________ Cell Phone_______________________ Email ______________________

Employer______________________________ Occupation____________________ Social Security # __________________

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

Spouse Information

Name____ Date of birth________________
Last First Middle

Residence ____
Street City Zip

Mailing Address ____
Street City Zip

Home Phone_______________________ Cell Phone_______________________ Work Phone_______________________

Employer______________________________ Occupation____________________ Social Security # __________________

Relationship to patient_______________________________________

Dental Insurance Information

Insured's Name____ Insured's Social Security #____________________

Insurance Company__________________________ Group No.__________________ Local No. ______________________

Insurance Co. Address____ Phone No. ____________________

Do you have dual coverage? No_____ Yes_____ If yes, please provide the information below:

Insured's Name____ Insured's Social Security #_______________________

Insurance Company__________________________ Group No.__________________ Local No. ______________________

Insurance Co. Address____ Phone No. ____________________

Emergency Information

Name of nearest relative not living with you ____

Complete address____
Street City Zip

Phone ____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____

Updates (date & initial) ____

MEDICAL HISTORY

Physician ____________________ Date of Last Visit ____________________
Address ____________________ Phone ____________________

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

Are you taking any medication? No Yes ____________________
Do you have a history of a major illness? No Yes____________________
Have you had any major operations? No Yes____________________
Have you ever been involved in a serious accident? No Yes ____________________

List any allergy or drug sensitivity that you have(including latex, food, metals, etc.) ____________________
____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions that you feel Dr. Martines should be aware of? ____________________
____

DENTAL HISTORY

Dentist ____________________ Date of last visit ____________________

What concerns you most about your teeth? ____________________

Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________
Yes No Has anyone in your family received orthodontic treatment? ____________________
How did they feel about the result? ____________________
What is your attitude toward receiving orthodontic treatment? ____________________

Yes No Are you presently in any dental pain? ____________________
Yes No Have you ever experienced any unfavorable reaction to dentistry? ____________________
Yes No Have you ever lost or chipped any teeth? ____________________
Yes No Have there been any injuries to face, mouth or teeth?____________________
Yes No Do you have any type of thumb or tongue habit?____________________
Yes No Are you a mouth breather?____________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?____________________
Yes No Are you aware of your jaw clicking or popping?____________________
Yes No Are you aware of clenching your teeth during the day? ____________________
Yes No Have you ever been told that you grind your teeth?____________________
Yes No Do you have “tension” headaches? ____________________
Yes No Are you aware that some appointments will be during school/work hours? ____________________

Female Patients only
Yes No Are you pregnant? ____________________
Yes No Has menstruation started? ____________________

UPDATES Medical and Dental History

Date __/__/__ ☐No changes ☐Changes ____________________

Date __/__/__ ☐No changes ☐Changes ____________________

Date __/__/__ ☐No changes ☐Changes ____________________

PLEASE READ

Orthodontics is a service that provides an improvement in the appearance of the teeth, in their general function and health. Teeth, gums and jaws are an intricate body part and at times fail to respond to treatment. If good oral hygiene is not practiced, dental decay and swollen gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Because teeth change position throughout life, there can be some movement and 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. Martines to perform a complete orthodontic evaluation, including photographs and x-rays.

Signature:____________________ Date:____________________