A B C

WELCOME TO THE FAMILY

PATIENT INFORMATION

Title: □Mr. □Mrs. □Ms. □Miss. □Dr. □Other ___________I prefer to be called _______________SSN#____________________
Name____________________________________ Birthdate_________________________ Home Phone_______________________
Residence ____
Street City Zip
Mailing Address____
Street City Zip
How long at this address?_____________Previous Address (If less than 3 years)____
Sex: □M □F Marital Status: Married□ Widowed□ Separated□ Divorced□ Single□ Minor□

E-mail__________________________________Cell Phone #1______________________Cell Phone #2______________________
Employer/School_______________________________________ Employer/School Phone ___________________________________
Employer/School Address ____
Street City Zip
Spouse or Parent's Name __________________________Employer____________________Work Phone_____________________
Whom may we thank for referring you? ____

EMERGENCY INFORMATION

Name of nearest relative not living with you ____
Complete address ____
Street City Zip
Phone____ E-Mail____

FINANCIAL RESPONSIBILITY

Name of person
Responsible for this Account ______________________________________ Relation to Patient ______________________________
Address (*if different from above*) ____ Driver's License#_________________
Phone #_________________________ E-Mail ____________________________________ DOB ___________________________
Employer____ Work Phone ____
Currently a patient in our office? □Yes □No

INSURANCE INFORMATIOIN

Name of Insured ____ Relation to Patient ___________________________________
Birthdate ___________________________ SSN# __________________________ Date Employed ___________________________
Employer____ Work Phone ____
Employer Address ____
Insurance Company ____________________________________ Group # ______________________ ID # ____________________
Insurance Co. Address____ Phone No.______________________________
Does this policy have orthodontic benefits? □ Yes □ No □ Don't know

ADDITIONAL INSURANCE

Name of Insured ____ Relation to Patient ___________________________________
Birthdate ___________________________ SSN# __________________________ Date Employed ___________________________
Employer____ Work Phone ____
Employer Address ____
Insurance Company ____________________________________ Group # ______________________ ID # ____________________
Insurance Co. Address____ Phone No.______________________________
Does this policy have orthodontic benefits? □ Yes □ No □ Don't know

GENERAL INFORMATION

What concerns you about your teeth? ____
Who suggested that you might need orthodontic treatment?____
Why did you select our office?____
Have you had any previous orthodontic treatment? Please describe ____
Have any other family members been treated in this office? Please name them. _______________________________
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. ______________________________

I understand that, where appropriate, credit bureau reports may be obtained.
Signature ____
Updates (date & initial) ____

MEDICAL HISTORY

Patient's Physician ____ Address ____
Date of last visit ______________________Reason ________________________________Next appointment ___________________
Most recent physical exam ______________________

Other physicians/health care providers being seen now:

Name ___________________________ City, State ________________________
Reason ___________________________
Name ___________________________ City, State ________________________
Reason ___________________________
Name ___________________________ City, State ________________________

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that you take and what you take them for.
____
____
____

Are you allergic to any medication?
____
____
____

Are you allergic to anything other than medication?
____
____
____

Do you take antibiotic pre-medication before any dental procedures? ☐ Yes ☐ No

Have you ever taken any medications to strengthen your bones? Please describe.
____
____

Do you or have you ever had a substance abuse problem? __________________________________

Have you chewed tobacco ☐ Yes ☐ No or smoked any substance or vaped? ☐ Yes ☐ No
If yes, what is the frequency? ___________________________________

Have you noticed any changes in your face or jaws? _______________________________________

Any other physical problems?
____
____

How often do you brush? _____________________________ How often do you floss? ______________________________

Women: Are you pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

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

Yes No Do you have a history of a major illness? ____

Yes No Have you had any operations? ____

Yes No Have you ever been involved in a serious accident? ____

yes no dk/u Have you ever taken intravenous medication for bone disorders or cancer such as bisphosphonates as Zometa (zolendromic acid), Aredia (pamidronate) or Didronel (etidronate)?

yes no dk/u Have you ever taken oral medication for bone disorders such as bisphosphonates Fosamax (alendronate), Actonel (ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate)?

yes no dk/u Abnormal bleeding/Hemophilia?
yes no dk/u Anemia?
yes no dk/u Any injuries to face, head, neck?
yes no dk/u Arthritis or joint problems?
yes no dk/u Asthma, Hay fever, Sinus Problems?
yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone Disorders?
yes no dk/u Bone fractures, or major injuries?
yes no dk/u Congenital Heart Defect?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Diabetes or low sugar?
yes no dk/u Dizziness?
yes no dk/u Epilepsy?
yes no dk/u Stomach ulcer, hyperacidity, acid reflux?
yes no dk/u Other Gastrointestinal Disorders?
yes no dk/u Heart Problems?
yes no dk/u Heart Murmurs?
yes no dk/u Heart Problem—Rheumatic?
yes no dk/u Angina, arteriosclerosis, stroke or heart attack?
yes no dk/u Chest pain, shortness of breath, tire easily, swollen ankles?
yes no dk/u Hepatitis / Liver Problems?
yes no dk/u Herpes?
yes no dk/u Gonorrhea, syphilis, herpes, sexually transmitted diseases?
yes no dk/u High Blood Pressure?
yes no dk/u Low Blood Pressure?
yes no dk/u Kidney problems?
yes no dk/u Immune system problems?
yes no dk/u History of osteoporosis?
yes no dk/u AIDS or HIV positive?
yes no dk/u Hepatitis, jaundice or other liver problem?
yes no dk/u Seizures, fainting spells, neurologic problem?
yes no dk/u Mental health disturbance or depression?
yes no dk/u Vision, hearing, or speech problems?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Skin disorder (other than common acne)?
yes no dk/u Do you eat a well-balanced diet?
yes no dk/u Frequent headaches or migraines?
yes no dk/u Frequent ear infections, colds, throat infections?
yes no dk/u Tonsil or adenoid condition?
yes no dk/u Do you frequently breathe through your mouth?
yes no dk/u Pneumonia?
yes no dk/u Prolonged bleeding / prolonged or easy bruising?
yes no dk/u Radiation/Chemotherapy?
yes no dk/u Rheumatic Fever?
yes no dk/u Tuberculosis?
yes no dk/u Tumor or Cancer?

Have you had allergies or reactions to any of the following:

yes no dk/u Latex (gloves, balloons)?
yes no dk/u Metals (jewelry, clothing snaps)?
yes no dk/u Acrylics?
yes no dk/u Local anesthetics (novocaine, lidocaine, xylocaine)?
yes no dk/u Aspirin?
yes no dk/u Ibuprofen (Motrin, Advil)?
yes no dk/u Penicillin?
yes no dk/u Other antibiotics?
yes no dk/u Plant pollens?
yes no dk/u Other:______________________________

Please elaborate if you answered "yes" to any of the above
____

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

FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders ____
Diabetes ____
Arthritis ____
Severe allergies ____
Unusual dental problems ____
Jaw size imbalance ____
Other family medical conditions? ____

DENTIST / DENTAL HISTORY

What concerns you most about your teeth? ____
Patient's Dentist ____
Address, City, State____ Phone:________________
Last seen ________________ Reason__________________________________
Next appointment ___________________
Other dentists/dental specialists now being seen:

Name ___________________________________ City, State _____________________
Reason___________________________________
Name ___________________________________ City, State _____________________
Reason___________________________________
Name ___________________________________ City, State _____________________
Reason___________________________________

yes no dk/u Are you presently in any dental pain?____
yes no dk/u Have you ever experienced any unfavorable reaction to dentistry? ____________________________
yes no dk/u Have your wisdom teeth been removed? ____
yes no dk/u Do you have supernumerary (extra) or congenitally missing teeth?
yes no dk/u Have you had permanent or extra (supernumerary) teeth been removed?
yes no dk/u Have you ever lost, injured or chipped any teeth? ___________________________________
yes no dk/u Have there been any injuries to face, mouth, or teeth? _______________________________
yes no dk/u Any sensitive or sore teeth?
yes no dk/u Is any part of your mouth sensitive to temperature? Where? _____________________________
yes no dk/u Is any part of your mouth sensitive to pressure? Where?_______________________________
yes no dk/u Do your gums bleed when you brush? ____
yes no dk/u Do you have bad taste or mouth odor?
yes no dk/u "Gum boils," frequent canker sores or cold sores?
yes no dk/u Have you ever been diagnosed with gum disease or pyorrhea?
yes no dk/u Jaw fractures, cysts, infections?
yes no dk/u Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ________________
yes no dk/u Are you aware of your jaw clicking or popping? _______________________________________
yes no dk/u Are you aware of clenching your teeth during the day? _________________________________
yes no dk/u Teeth causing irritation to lip, cheek or gums?
yes no dk/u Any broken or missing fillings?
yes no dk/u Have you ever been told or are aware that you grind your teeth? ___________________________
yes no dk/u Do you have "tension" headaches? ____
yes no dk/u Have you ever experienced chronic ringing in your ears? ________________________________
yes no dk/u Soreness in jaw muscles or face muscles?
yes no dk/u Do you experience any difficulty in chewing or opening jaw?
yes no dk/u Have you ever been treated for "TMJ" or "TMD" problems?
yes no dk/u Do you have any type of thumb or tongue habit? _______________________________________
yes no dk/u Are you a mouth breather? ____
yes no dk/u Does food get stuck between your teeth?
yes no dk/u Any teeth treated with root canals or pulpotomies?
yes no dk/u History of speech problems or speech therapy?
yes no dk/u Difficulty breathing through nose?

yes no dk/u Mouth breathing habit or snoring at night?
yes no dk/u Abnormal swallowing (tongue thrust)?
yes no dk/u Frequent oral habits (sucking finger, chewing pen, etc.)?
yes no dk/u Any serious trouble associate with previous dental treatment?
yes no dk/u Have you ever had an orthodontic consultation or treatment before now
If yes, who and when? ____
What is your attitude toward receiving orthodontic treatment? _______________________________________
yes no dk/u Has anyone in your family received orthodontic treatment? ____
How did they feel about the result? ____
yes no dk/u Are you aware that some appointments will be during work hours?

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 also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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. Senties to perform a complete orthodontic evaluation.

Signature: ____Date: ____________________

RELEASE AND WAIVER
I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.
Signature ____ Date___________________

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature ____ Date___________________

Orthodontist Signature____ Date___________________

MEDICAL HISTORY UPDATES OR CHANGES

Changes ____
Patient Signature ____ Date________________________________
Dental Staff Signature ____ Date______________________________

Changes ____
Patient Signature ____ Date________________________________
Dental Staff Signature ____ Date______________________________

Changes ____
Patient Signature ____ Date________________________________
Dental Staff Signature ____ Date______________________________