LAKEVIEW ORTHODONTICS

Date____________________ Case #____________________

Patient's Name ____________________ Age_______ Birth Date__________ Sex ____

Address ____________________ City ______________ State______ Zip Code__________ SS # ______________

Cell Phone ____________________ Email ____________________

Home Phone ____________________ Driver's License #______________

Employed by ____________________ Occupation ______________

Business Address ____________________ Business Phone ______________

Spouse's Name ____________________ Address ______________ Birth Date __________

Employed By ____________________ Occupation______________ SS # __________

Business Address ____________________ Business Phone ______________

Patient's Dentist ____________________ Last Visit ______________

Dental Insurance Information ____________________

Whom may we thank for referring you? ____________________

Main Complaint ____________________

MEDICAL HISTORY

Please check any of the following conditions or problems patient has experienced

Anemia .... ( )	Emotional .... ( )	Fainting or dizziness .... ( )	Mumps .... ( )
Asthma .... ( )	Endocrine (Hormone) .... ( )	Hearing .... ( )	Rheumatic fever .... ( )
Bone (fracture) .... ( )	Epilepsy .... ( )	Heart .... ( )	Speech .... ( )
Convulsions .... ( )	Excessive bleeding .... ( )	Kidney .... ( )	Tuberculosis .... ( )
Diabetes .... ( )	Eye .... ( )	Liver .... ( )	Hepatitis .... ( )
			ADD or ADHD........ ( )

Other ____________________

Is patient in good health? Yes ( ) No ( ) If no, explain ____________________

Have you or any of your family members been diagnosed as being HIV positive?____________________

Does patient have frequent Colds_________ Sore throats_________ Ear Infections_________ or have Tubes in ears ______________

Have tonsils and adenoids been removed?_________ If so, what age ____________________

List any drugs or medications now being taken:____________________ Give reasons: ______________

List any allergies or drug sensitivity: ____________________

DENTAL HISTORY

Did patient have decayed teeth by age four? .... Yes ( ) No ( )

Does patient have decayed teeth now? .... Yes ( ) No ( )

Have there been any injuries to the face, mouth or teeth? .... Yes ( ) No ( )

Is patient's oral hygiene: Poor_________ Fair_________ Excellent_________ Sporadic_________

Have you been informed of any missing or extra permanent teeth? .... Yes ( ) No ( )

Has an orthodontist been consulted previously? .... Yes ( ) No ( )

Explain........

Does patient see dentist for regular dental treatment? .... Yes ( ) No ( ) How often?__________

Has patient ever experienced "jaw" or "joint" pain? Yes ( ) No ( )

Describe ____________________

REMARKS ____________________

Signature____________________

Insurance: Do you have dental insurance and do you plan to file?____________________

Insured Name:____________________ DOB:______________ Policy #:______________