

# LAKEVIEW ORTHODONTICS

Date \_\_\_\_\_ Case # \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS # \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_ 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 #: \_\_\_\_\_