Exam Date:___________________

midwestorthodontics

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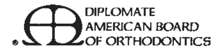

Welcome to Our Office! So that we might become better acquainted, please complete both sides of this form.

Adolescent Patient Information

Name:______________________________________ ________________ Home Phone: (____) ________________
First MI Last Nickname/Preferred

Address:______________________________ City:______________ State:________ Zip: __________

Birthdate: ___/___/___ Sex_____ School Name:______________________________Grade: __________

Who is the Responsible Party? ____________________________ E-mail____________________________

Father Information

Name:______________________________________

Address:____________________________________

City:____________________ State:_____Zip:________

Home Phone:__________ Work Phone: ____________

Birthdate:__________ SSN:_____-_____-________

Father/Insurance Information

Employer Name: ______________________________

Employer Address: ____________________________

Employer City:____________ State:_____Zip: ______

Occupation: _________________________________

Do you have orthodontic ins. coverage? Yes___ No___

Dental Insurance Co: ___________________________

Insurance Address: ____________________________

Insurance City:____________ State:_____Zip: ______

Insurance Phone: (_____)______________Ext. ______

Group #:____________ Local or Union # __________

Mother Information

Name:______________________________________

Address:____________________________________

City:____________________ State:_____Zip:________

Home Phone:__________ Work Phone: ____________

Birthdate:__________ SSN:_____-_____-________

Mother/Insurance Information

Employer Name: ______________________________

Employer Address: ____________________________

Employer City:____________ State:_____Zip: ______

Occupation: _________________________________

Do you have orthodontic ins. coverage? Yes___ No___

Dental Insurance Co: ___________________________

Insurance Address: ____________________________

Insurance City:____________ State:_____Zip: ______

Insurance Phone: (_____)______________Ext. ______

Group #:____________ Local or Union # __________

Dentist Name: Dr. ____________________________ Date last dental exam? ________________________

Other dental specialist seen recently: _______________ Who may we thank for referring you? ______________

Sports/Hobbies: ____

Names and ages of other children: ____

Has anyone in your family been to our office before? No___ Yes___ If Yes, please explain ________________

MEDICAL INFORMATION

Physician's Name:________________________ Address:________________________________ Phone:________________

My last physical was on______________________

1. Are you in good health? No____ Yes____ Explain:________________________________
2. Any major change in your health recently? No____ Yes____ Explain:________________________________
3. Are you now under a physician's care? No____ Yes____ Explain:________________________________
4. Are you taking any medication(s)? No____ Yes____ List:________________________________
5. Are you allergic to any medicine(s)? No____ Yes____ List:________________________________
6. Have your Tonsils or Adenoids been removed? No____ Yes____ Explain:________________________________
7. Do you wear contact lenses? No____ Yes____
8. Women: Are you Pregnant? No____ Yes____
9. Do you have or have had any of the following diseases or problems?

Heart Murmur	No____	Yes____	Hepatitis	No____	Yes____	Arthritis	No____	Yes____
Heart Disease	No____	Yes____	Diabetes	No____	Yes____	Freq.Headaches	No____	Yes____
Rheumatic Fever	No____	Yes____	Kidney Disease	No____	Yes____	Cancer	No____	Yes____
Endocrine Disorders	No____	Yes____	Liver Disease	No____	Yes____	Bone Disorders	No____	Yes____
Prolonged Bleeding	No____	Yes____	AIDS/HIV	No____	Yes____	Growth Disorder	No____	Yes____
Anemia	No____	Yes____	Tuberculosis	No____	Yes____	Epilepsy	No____	Yes____
Bronchitis	No____	Yes____	Asthma/Hayfever	No____	Yes____	Allergies	No____	Yes____

10. Have you had any serious trouble associated with any previous dental treatment? No____ Yes____

    Explain:____

11. Are there any other medical conditions or problems that you think we should be aware of? No____ Yes____

    Explain____

DENTAL HISTORY

What is your main orthodontic concern? ____

What are your dentist's concerns? ____

Have you had any face or dental injuries? ____

Have you been informed of missing or extra teeth? No ___ Yes ___ Explain ____________________________

Have any permanent teeth been removed? No ___ Yes ___ Explain ____________________________

Are you aware of any "Gum" problems? No ___ Yes ___ Explain ____________________________

Do your jaw joints make any noise or hurt when you open or close your mouth? No ___ Yes ___ Explain ____________________________

Has your mouth ever locked open or closed? No ___ Yes ___ Explain ____________________________

Have you had any previous orthodontic treatment? No ___ Yes ___ Explain ____________________________

Has anyone in the family had braces? No ___ Yes ___ Explain ____________________________

Do you play any musical instruments? No ___ Yes ___ Explain ____________________________

May we use your treatment photos for promotional/educational purposes? No ___ Yes ___

Do you have or have had any of the following habits?

Thumb Sucking	No____	Yes____	Tongue Thrusting	No____	Yes____	Clenching Teeth	No____	Yes____
Finger Sucking	No____	Yes____	Mouth Breathing	No____	Yes____	Grinding Teeth	No____	Yes____
Lip Biting	No____	Yes____	Speech Problems	No____	Yes____			

What would you like orthodontic treatment to accomplish?____

I, the undersigned, have given the above medical and dental information and consider it accurate. If there are any changes to this Patient History Record, I will so inform this practice.

______________________________ Signature (Patient/Responsible Party) __________ Date ______________________________ Reviewed By (Office Use Only) __________ Date