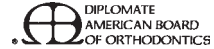


midwestorthodontics



16 Emerald Terrace
Swansea, IL 62226
TEL: 618-236-9700 FAX: 618-236-9877
www.midwestsmiles.com

Exam Date: _____



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

Adult Patient Information

Name: _____ Home Phone: (____) _____
First MI Last Nickname/Preferred
Address: _____ City: _____ State: _____ Zip: _____
Birthdate: ___/___/___ Sex: _____ Marital Status: _____ Social Security Number: _____ - _____ - _____
Who is the Responsible Party? _____ E-mail _____

Employer/Insurance Information

Employer Name: _____
Employer Address: _____
Employer City: _____ State: _____ Zip: _____
Occupation: _____
Do you have orthodontic insurance coverage? Yes ___ No ___
Dental Insurance Co: _____
Insurance Address: _____
Insurance City: _____ State: _____ Zip: _____
Insurance Phone: (____) _____ Ext: _____
Group #: _____ Local or Union #: _____

Spouse Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Birthdate: _____ SSN: _____ - _____ - _____

Spouse Employer/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 #: _____

Other Information

Dentist Name: Dr. _____
Date last dental exam? _____
Who may we thank for referring you? _____
Other dental specialist seen recently: _____

Sports/Hobbies: _____

Names and ages of 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 |
| Heart Disease | No___ | Yes___ | Diabetes |
| Rheumatic Fever | No___ | Yes___ | Kidney Disease |
| Endocrine Disorders | No___ | Yes___ | Liver Disease |
| Prolonged Bleeding | No___ | Yes___ | AIDS/HIV |
| Anemia | No___ | Yes___ | Tuberculosis |
| Bronchitis | No___ | Yes___ | Asthma/Hayfever |
| | | | Arthritis |
| | | | Freq. Headaches |
| | | | Cancer |
| | | | Bone Disorders |
| | | | Growth Disorder |
| | | | Epilepsy |
| | | | Allergies |

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 instrument? No___ Yes___ What instrument _____

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