EDWARDS
ORTHODONTICS

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***Patient's Name: _____ *Preferred Name: _____**

Today's Date _____ **Birth Date:** _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Age: _____ Sex: _____ SSN: _____-_____-_____

E-Mail Address: _____ School: _____ Grade: _____

Siblings Names & Ages: _____

Sports / Hobbies: _____ Musical Instruments Played: _____

Whom may we thank for referring you to our office? _____

Why did you choose our office? _____

Is there anything you would like to speak about in private? Yes ☐ No ☐

Dentist Name: _____ Date of Last Visit: _____ Last X-Rays: _____

Is there anyone else in your family you would like us to see in the future? _____If yes, specify age(s): _____

Are there any other family members that already see us? _____ Name: _____

Chief Orthodontic Concern: _____

Name of nearest relative not living with you: _____Phone_____

Complete Address: _____City: _____State: _____Zip: _____

Responsible Party Information Please complete all fields.

Primary Responsible Party: _____ Relationship to patient: _____

Address (**If different than patient**): _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone**:** _____

Social Security Number: _____- _____-_____ Birth Date: _____ Relationship to Patient: _____

Employer: _____Occupation: _____ Years Employed: _____

Email Address: _____Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Secondary Responsible Party or Spouse: _____ Relationship to patient: _____

Address (**If different than patient**): _____City: _____State: _____Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone**:** _____

Social Security Number: _____- _____-_____ Birth Date: _____ Relationship to Patient: _____

Employer: _____Occupation: _____ Years Employed: _____

Email Address: _____Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Dental Insurance Information Please present card if available.

Policy Holder: _____ Birth Date: _____/_____/_____ SSN #: _____-_____-_____

Insurance Company: _____ Group No.: _____ ID#: _____

Insurance Co Address: _____City:_____ State:_____Zip: _____

Do you have other coverage? ☐ Yes ☐ No

Policy Holder: _____ Birth Date: _____/_____/_____ SSN #: _____-_____-_____

Insurance Company: _____ Group No.: _____ ID#: _____

Insurance Co Address: _____City:_____ State:_____Zip: _____

PLEASE COMPLETE REVERSE SIDE

Medical History

Pt. Name: _____

Physician: _____ Date of Last Visit: _____

Check Yes or No if the patient has a history of the following:

Aids/HIV	☐ Yes ☐ No	Cortisone Treatment	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Autoimmune	☐ Yes ☐ No	Diabetes	☐Yes ☐No	Nervous Disorder	☐Yes ☐No
Immune Problems	☐ Yes ☐ No	Endocrine Problems	☐Yes ☐No	Organ Transplant	☐Yes ☐No
Allergies	☐ Yes ☐ No	Emotional Disorders	☐Yes ☐No	Painful Chewing	☐Yes ☐No
Seasonal Allergies	☐Yes ☐ No	Epilepsy	☐Yes ☐No	Periodontal Problems	☐Yes ☐No
Drug Allergies	☐Yes ☐ No	Fainting, Dizziness	☐Yes ☐No	Smoke/Tobacco Use	☐Yes ☐No
Anemia	☐ Yes ☐No	Headaches	☐Yes ☐No	Pregnant	☐Yes ☐No
Arthritis	☐Yes ☐No	Liver Problems	☐Yes ☐No	Due Date_____	
Asthma	☐Yes ☐No	Heart Condition	☐Yes ☐No	Prolonged Bleeding	☐Yes ☐No
Bone Disorders	☐Yes ☐No	Congenital Heart Condition	☐Yes ☐No	Radiation Treatment	☐Yes ☐No
Cancer	☐Yes ☐No	Chest Pains	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	Artificial Heart Valves	☐Yes ☐No	Seizures	☐Yes ☐No
Muscular Disorders	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Thyroid	☐Yes ☐No
Chronic Neck Pain	☐Yes ☐No	Hepatitis	☐Yes ☐No	TMJ Problems	☐Yes ☐No
Clicking of Jaw	☐Yes ☐No	Sinus Problems	☐Yes ☐No	Tooth Grinding	☐Yes ☐No
Cold Sore	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Tuberculosis	☐Yes ☐No

Have tonsils and adenoids been removed? ☐Yes ☐No What age? _____

List any drugs or medications now being taken, give reason: _____

List **ALL** drug allergies or drug sensitivities: _____

Are you allergic to LATEX? _____ Other Medical Conditions: _____

Dental History

Have there been injuries to the face, mouth, or teeth?	☐Yes ☐No
If yes, please give details: _____	
Does the patient bite their nails?	☐Yes ☐No
Has the patient had a thumb, finger, sucking habit? Until what age_____?	☐Yes ☐No
Has the patient had primary (baby) teeth removed early? At what age_____?	☐Yes ☐No
Does the patient have a history of speech problems?	☐Yes ☐No
Is there a history of mouth breathing, snoring, or difficulty breathing?	☐Yes ☐No
Does the patient have jaw pain or tiredness? Pain around ear?	☐Yes ☐No
Does the patient grind their teeth? Day _____ Night _____ Both _____	☐Yes ☐No
Have you been informed of any missing or extra permanent teeth?	☐Yes ☐No
Has an orthodontist been consulted previously? Who_____?	☐Yes ☐No
Has the patient had previous orthodontic treatment? By Whom _____?	☐Yes ☐No
Is the patient concerned about spaced, crooked or protruding teeth?	☐Yes ☐No
Is the patient aware or concerned about under or over developed jaw?	☐Yes ☐No
Does the patient have any relatives with similar tooth or jaw relationships?	☐Yes ☐No

Other dental conditions to note: _____

How often does patient brush?: _____ floss?: _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

Primary Responsible Party Signature: _____ Date: _____