

Welcome to Foote Orthodontics

A beautiful smile is a wonderful asset. We are pleased you came to see us about your smile. Please fill out this form completely. The better we communicate, the better we can care for you or your child.

Patient Information

Today's Date _____

Name _____

Mr ___ Mrs ___ Ms ___ Dr ___ Child ___

Nickname _____

Male ___ Female ___

Birthdate _____ Age _____

School _____ Grade _____

Employer _____

Home address _____

Cell phone _____

Email _____

facebook name _____

Person financially responsible for account

Mother ___ Father ___ Self ___ Spouse ___

Name _____

Address _____

Home phone _____

Cell phone _____

Emergency Contact Name _____

Phone _____

Relation to patient _____

General Dentist _____

Date of last dental visit _____

Whom may we thank for referring you? _____

Other siblings/ages _____

Marital status (for parents, if patient is child) _____

Mother/wife

Name _____

Address, if different than patient _____

Employer _____

Cell phone _____

Father/husband

Name _____

Address, if different than patient _____

Employer _____

Cell phone _____

Dental Insurance

Insurance company _____

Policy holder _____

Patient ___ Father ___ Mother ___

Policy holder's birth date _____

Policy ID number _____

Social security number _____

Dental History for Patient

Do you like your smile? _____

Your current dental health is: ___ good ___ fair ___ poor

Do your gums ever bleed? ___ no ___ yes

Have you ever had an injury to your: (circle)

mouth teeth chin Describe _____

Have you ever experienced pain in your jaw joint? (TMJ/TMD)? ___ no ___ yes

Thumb, finger or sucking habit ___ no ___ yes Until what age? ___

Abnormal swallowing habit (tongue thrusting)? _____

History of speech problems? _____

Mouth breathing habit, snoring or difficulty breathing? _____

Tooth grinding or jaw clenching? _____

Does the patient now have or ever had any of the following:

___ no ___ yes Shingles

___ no ___ yes Stomach Ulcers/Colitis

___ no ___ yes Endocrine/thyroid problems

___ no ___ yes Sickle Cell

___ no ___ yes Tonsil/Adenoid conditions

___ no ___ yes Ear/Nose/Throat conditions

___ no ___ yes Kidney Trouble

___ no ___ yes Asthma

___ no ___ yes Severe/ Frequent headaches

___ no ___ yes Hepatitis / Liver Disease

___ no ___ yes High/Low Blood Pressure

___ no ___ yes Artificial bone/joint/valves

___ no ___ yes Diabetes

___ no ___ yes Venereal Disease

___ no ___ yes History of eating disorder (anorexia/bulimia)

___ no ___ yes A.D.D./ A.D.H.D.

___ no ___ yes Herpes/cold sores

___ no ___ yes Rheumatoid/Arthritic conditions
___ no ___ yes Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, congenital heart defect, heart murmur or rheumatic heart disease)

___ no ___ yes Glaucoma

___ no ___ yes Skin Disorder

Does the patient smoke or use tobacco in any form? _____

___ no ___ yes Tuberculosis

___ no ___ yes Radiation/ Chemotherapy

Substance Abuse? _____

___ no ___ yes Anemia

___ no ___ yes Hemophilia

Does the patient have any other medical problems or ALERTS not listed here?

___ no ___ yes Blood Disorders

___ no ___ yes AIDS/HIV+

___ no ___ yes Bleeding problems

___ no ___ yes Emphysema

___ no ___ yes Blood transfusion

___ no ___ yes Osteoporosis

___ no ___ yes Sinus problems

___ no ___ yes Fainting Spell/ Epilepsy/Seizures

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Also, in signing this you understand that your child's photo may be displayed on our facebook page as a means of congratulating them on starting their treatment or showcasing their newly straightened smile. Pictures on facebook will only be shared with other members of our Foote Orthodontic family, and no last names will be listed. Thank you.

Signature _____

Name (print) _____

Medical History for Patient

Current general health: ___ good ___ fair ___ poor

Have you been advised that you require an antibiotic prior to treatment? ___ no ___ yes.

Antibiotic _____

Are you currently taking any prescription/over the counter drugs? _____

If yes, which ones? _____

Do you have a chronic illness?

Do you have allergies to: ___ aspirin ___ dental anesthetics

___ Penicillin ___ metals/plastics ___ environmental ___ ibuprofen

___ latex ___ codeine ___ Erythromycin ___ Tetracycline ___ vinyl

___ acrylic ___ sulfa drugs ___ codeine/other narcotics ___ Other

Have you ever been hospitalized ___ no ___ yes, reason?
