

FOOTE ORTHODONTICS

Patient Information

Today's Date _____

Name _____

Nickname _____

Male ___ Female ___

Birthdate _____ Age _____

School _____

Grade _____

Home address _____

Home phone _____

Cell phone _____

Email _____

Person financially responsible for account

Mother ___ Father ___ Guardian ___

Dental Insurance

Insurance company _____

Policy holder _____

Father ___ Mother ___

Policy holder's birth date _____

Policy ID number _____

Social security number _____

General Dentist _____

Date of last dental visit _____

Whom may we thank for referring you? _____

Other siblings/ages _____

Marital status (of parents) _____

Mother/Guardian

Name _____

Address, if different than patient _____

Employer _____

Cell phone _____

Father/Guardian

Name _____

Address, if different than patient _____

Employer _____

Cell phone _____

Emergency Contact

Name _____

Phone _____

Relation to patient _____

Treatment Interested In:

Invisalign ___ Braces ___ Unsure ___

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

If yes: ___ current ___ past

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? _____

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

___ no ___ yes Shingles

___ no ___ yes Sickle Cell

___ no ___ yes Kidney Trouble

___ no ___ yes Hepatitis / Liver Disease

___ no ___ yes Diabetes

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

___ no ___ yes Tuberculosis

___ no ___ yes Anemia

___ no ___ yes Blood Disorders

___ no ___ yes Bleeding problems

___ no ___ yes Blood transfusion

___ no ___ yes Sinus problems

___ no ___ yes Stomach Ulcers/Colitis

___ no ___ yes Tonsil/Adenoid conditions

___ no ___ yes Asthma

___ no ___ yes High/Low Blood Pressure

___ no ___ yes Psychiatric problems

___ no ___ yes Herpes/cold sores

___ no ___ yes Skin Disorder

___ no ___ yes Radiation/ Chemotherapy

___ no ___ yes Hemophilia

___ no ___ yes AIDS/HIV+

___ no ___ yes Fainting Spell/ Epilepsy/Seizures

___ no ___ yes Endocrine/thyroid problems

___ no ___ yes Ear/Nose/Throat conditions

___ no ___ yes Severe/ Frequent headaches

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 ___ other narcotics ___ other: _____

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

___ no ___ yes Artificial bone/joint/valves

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

___ 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)

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

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 and/or video may be displayed on our Social Media as a means of congratulating them on starting their treatment or showcasing their newly straightened smile. Pictures on Social Media will only be shared with other members of our Foote Orthodontic family, and no last names will be listed. Thank you.

Signature (parent) _____

Name (print) _____

We would love to interact with you on Social Media!

Facebook _____ Twitter _____ Instagram _____