FOOTE ORTHODONTICS

Patient Information

Today's Date_____

Name _____

Mr.___ Mrs.____ Ms.____ Dr.____

Nickname_____

Male____ Female___

Birthdate_____ Age _____

Employer_____

Home address_____

_____

Home phone_____

Cell phone_____

Email_____

General Dentist_____

Date of last dental visit_____

Whom may we thank for referring you?_____

Children/ages_____

_____

Marital status _____

Spouse

Name_____

Address, if different than patient_____

_____

Employer_____

Cell phone_____

Person financially responsible for account

Self_____ Spouse _____

Dental Insurance

Insurance company_____

Policy holder _____

Self_____ Spouse _____

Policy holder's birth date_____

Policy ID number _____

Social security number _____

Emergency Contact

Name_____

Phone_____

Relation to patient_____

Treatment Interested In:

Invisalign ___ Braces ___ Unsure ___

What is your main concern?:

_____

_____

_____

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

Abnormal swallowing habit (tongue thrusting)?_____

History of speech problems?_____

Mouth breathing habit, snoring or difficulty breathing?_____

Tooth grinding or jaw clenching?_____

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?

_____

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 Glaucoma

___ 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 Emphysema

___ no ___ yes Osteoporosis

___ no ___ yes Fainting Spell/ Epilepsy/Seizures

___ no ___ yes Endocrine/thyroid problems

___ no ___ yes Ear/Nose/Throat conditions

___ no ___ yes Severe/ Frequent headaches

___ 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 smoke or use tobacco in any form?_____

Substance Abuse?_____

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 _____

Name (print)_____

We would love to interact with you on Social Media!

Facebook_____ Twitter _____ Instagram_____