DIXON ORTHODONTICS

American Association of Orthodontists

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# PATIENT INFORMATION FORM

## PATIENT

Date _____
Patient's first name _____
Last name _____
Middle initial _____
Birth date _____
Sex ☐ female ☐ male
Primary Contact _____

Social Security # _____
Home Address _____
City, State, Zip Code _____
Home phone _____
Cell phone _____
Email address _____

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

☐ My Dentist ☐ A Friend ☐ Online // website_____ ☐ Other_____

**Who is your dentist?** _____

## FINANCIAL RESPONSIBILITY

who is financially responsible for this account?

_____
Address _____
City, State, Zip _____
Home phone _____
Cell phone _____
Email _____

Social Security # _____
Employer _____
Years at current employer _____
Housing ☐ own ☐ rent
Occupation _____

## DENTAL INSURANCE

Primary policy holder's full name

_____
Birth Date _____
Social Security # _____
Relationship to Patient _____
Social Security # _____
Address and phone (if not listed above)

_____

Insurance Company _____
Employer _____
Address _____
Group # _____
ID # _____
Does this policy have orthodontic benefits?

☐ Yes ☐ No ☐ Don't Know

**I understand that, where appropriate, credit bureau reports may be obtained and will be kept confidential.**

Signature _____ Date _____
*(Parent's signature if minor)*

**MEDICAL DENTAL HISTORY FORM**

## MEDICAL HISTORY

Now or in the past, have you had

| Yes | No | DK/U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Birth defects or hereditary problems? |
| ☐ | ☐ | ☐ | Bone fractures or major injuries? |
| ☐ | ☐ | ☐ | Asthma, sinus problems, hayfever? |
| ☐ | ☐ | ☐ | Arthritis or joint problems? |
| ☐ | ☐ | ☐ | Endocrine or thyroid problems? |
| ☐ | ☐ | ☐ | Diabetes or low sugar? |
| ☐ | ☐ | ☐ | Kidney problems? |
| ☐ | ☐ | ☐ | Cancer, tumor, radiation, chemotherapy? |
| ☐ | ☐ | ☐ | Stomach ulcer, hyperacidity, acid reflux? |
| ☐ | ☐ | ☐ | Immune system problems? |
| ☐ | ☐ | ☐ | History of osteoporosis? |
| ☐ | ☐ | ☐ | Gonorrhea, syphilis, herpes, STD's? |
| ☐ | ☐ | ☐ | AIDS or HIV Positive? |
| ☐ | ☐ | ☐ | Hepatitis, jaundics, other liver problems? |
| ☐ | ☐ | ☐ | Polio, mononucleosis, tuberculosis? |
| ☐ | ☐ | ☐ | Pneumonia? |
| ☐ | ☐ | ☐ | Seizures, fainting spells, neurologic problems? |
| ☐ | ☐ | ☐ | Mental health disturbance or depression? |
| ☐ | ☐ | ☐ | Vision, hearing, or speech problems? |
| ☐ | ☐ | ☐ | History of eating disorder? |
| ☐ | ☐ | ☐ | High or low blood pressure? |
| ☐ | ☐ | ☐ | Excessive bleeding, bruising, anemia? |
| ☐ | ☐ | ☐ | Chest pain, shortness of breath, tire easily? |
| ☐ | ☐ | ☐ | Heart defects, heart murmur? |
| ☐ | ☐ | ☐ | Angina, arteriosclerosis, stroke, heart attack? |
| ☐ | ☐ | ☐ | Skin disorder (other than acne)? |
| ☐ | ☐ | ☐ | Frequent headaches or migraines? |
| ☐ | ☐ | ☐ | Frequent ear infections, cold, throat infections? |
| ☐ | ☐ | ☐ | Tonsil or adenoid condition? |

## DENTAL HISTORY

Now or in the past, have you had

| Yes | No | DK/U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Permanent or extra teeth removed? |
| ☐ | ☐ | ☐ | Supernumerary teeth? |
| ☐ | ☐ | ☐ | Congenitally missing teeth? |
| ☐ | ☐ | ☐ | Chipped or injured teeth? |
| ☐ | ☐ | ☐ | Sensitive or sore teeth? |
| ☐ | ☐ | ☐ | Bleeding gums, bad taste or odor? |
| ☐ | ☐ | ☐ | Jaw fractures, cysts, infections? |
| ☐ | ☐ | ☐ | Root Canal treatment? |
| ☐ | ☐ | ☐ | Frequent canker sores or cold sores? |
| ☐ | ☐ | ☐ | History of speech problems? |
| ☐ | ☐ | ☐ | Speech therapy? |
| ☐ | ☐ | ☐ | Difficulty breathing through nose? |
| ☐ | ☐ | ☐ | Food impaction between the teeth? |
| ☐ | ☐ | ☐ | Mouth breathing habit or snoring? |
| ☐ | ☐ | ☐ | Finger or thumb sucking? |
| ☐ | ☐ | ☐ | Chewing on pens? |
| ☐ | ☐ | ☐ | Teeth causing irritation to gums, lips? |
| ☐ | ☐ | ☐ | Abnormal swallowing (tounge thurst)? |
| ☐ | ☐ | ☐ | Tooth grinding or clenching? |
| ☐ | ☐ | ☐ | Clicking, locking in jaw joints? |
| ☐ | ☐ | ☐ | Soreness in jaw muscles/face muscles? |
| ☐ | ☐ | ☐ | Ringing in ears? |
| ☐ | ☐ | ☐ | Difficulty in chewing or opening jaws? |
| ☐ | ☐ | ☐ | Have you ever been treated for "TMJ" or "TMD" problems? |
| ☐ | ☐ | ☐ | Any broken or missing fillings? |
| ☐ | ☐ | ☐ | Have you ever had periodontal disease? |
| ☐ | ☐ | ☐ | Have you ever had orthodontic treatment? |

**ALLERGIES** List any medications, foods, or other substances that you have had an allergic reaction to.

_____

## MEDICATIONS

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Have you ever taken medication to strengthen your bones? Please describe below.

_____

## FAMILY MEDICAL HISTORY

Have your parents or siblings ever had any of the following problems? If so, please explain.

Bleeding disorders, arthritis, unusual dental problems, diabetes, severe allergies, jaw size imbalance.

_____

## RELEASE AND WAIVER

*I authorize release of any information regarding my orthondontic treatment to my dental and/or medical insurance company*

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature _____ Date _____

Witness Signature _____ Date _____