Patient Information

Patient's Name ______________________ ______________________ ______________________
First Middle Last

Preferred Name (Nickname): ______________________ Gender: ☐ Male ☐ Female

Birthdate:____________Name of School______________________Grade Level__________

Please list any hobbies or interests ______________________

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

Medical History

Physician ______________________Date of Last Visit ______________________

Please check Yes or No (If Yes, please fill in details)

Is patient taking any medication? ______________________ ☐ Yes ☐ No
Has patient's physician advised prophylactic antibiotics for dental procedures? ______________________ ☐ Yes ☐ No
Is patient allergic to any medication? ______________________ ☐ Yes ☐ No
Does patient have a history of a major illness? ______________________ ☐ Yes ☐ No
Has patient had any major operations? ______________________ ☐ Yes ☐ No
Have patient ever been involved in a serious accident? ______________________ ☐ Yes ☐ No
Are there any medical conditions we have not discussed that you feel we should be aware of? ____________ ☐ Yes ☐ No

Check any of the medical conditions below that the patient has had or currently has:

☐ Abnormal bleeding/Hemophilia
☐ Anemia
☐ Arthritis
☐ Asthma or Hayfever
☐ Bone Disorders
☐ Congenital Heart Defect
☐ Diabetes
☐ Dizziness
☐ Radiation/Chemotherapy
☐ Gastrointestinal Disorders
☐ Heart Problems
☐ Heart Murmur
☐ Hepatitis/Liver problems
☐ Herpes
☐ High Blood Pressure
☐ HIV / Aids
☐ Kidney problems
☐ Nervous Disorders
☐ Pneumonia
☐ Prolonged Bleeding
☐ Epilepsy
☐ Rheumatic Fever
☐ Tuberculosis
☐ Tumor or Cancer

Dental History

Current Dentist ______________________Date of Last Visit ______________________

Please check Yes or No (If Yes, please fill in details)

Is patient presently in any dental pain? ______________________ ☐ Yes ☐ No
Is patient currently seeing any dental specialists (Periodontist, Prosthodontist, Oral Surgeon)?____________ ☐ Yes ☐ No
Has patient ever experienced any unfavorable reaction to dentistry? ______________________ ☐ Yes ☐ No
Has patient ever broken or chipped any teeth? ______________________ ☐ Yes ☐ No
Have there been any injuries to face, mouth or teeth?______________________ ☐ Yes ☐ No
Is any part of patient's mouth sensitive to temperature or pressure?______________________ ☐ Yes ☐ No
Do the patient's gums bleed when they brush? ______________________ ☐ Yes ☐ No
Does the patient have any type of thumb or tongue habit? ______________________ ☐ Yes ☐ No
Has the patient ever seen an orthodontist? If yes, who and when?______________________ ☐ Yes ☐ No
Does the patient's teeth or jaws ever feel uncomfortable when they awake in the morning? ____________ ☐ Yes ☐ No
Is the patient aware of his/her jaw clicking or popping? ______________________ ☐ Yes ☐ No
Is the patient aware of clenching or grinding his/her teeth during the day? ______________________ ☐ Yes ☐ No
Have you ever heard the patient grind his/her teeth at night? ______________________ ☐ Yes ☐ No
Does the patient have frequent headaches?______________________ ☐ Yes ☐ No

Family Information

Same as previously examined sibling: Sibling's Name ______________ First ______________ Last

Mother's Name: ______________ First ______________ Last

Occupation: ______________ Employer: ______________ Yrs Employed ______

Home Address ______________ Street ______________ City ______________ Zip

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

E-mail Address: ______________

Preferred Contact Method for Appointment Reminders: Home Phone Cell Phone E-Mail Text to Cell Phone

Father's Name: ______________ First ______________ Last

Occupation: ______________ Employer: ______________ Yrs Employed ______

Home Address ______________ Street ______________ City ______________ Zip

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

E-mail Address: ______________

Preferred Contact Method for Appointment Reminders: ☐ Home Phone ☐ Cell Phone ☐ E- Mail ☐ Text to Cell Phone

Parent Status: ☐ Married Step-Mother's Name (if applicable): ______________
☐ Divorced Step Father's Name (if applicable): ______________

Sibling Name: ______________ First ______________ Last Age ______________

Sibling Name: ______________ First ______________ Last ______________

Sibling Name: ______________ First ______________ Last ______________

Financial Information

Responsible Billing Party: ☐ Father (Above) ☐ Mother (Above) ☐ Other (Please complete below)

Name: ______________ First ______________ Last

Occupation: ______________ Employer: ______________ Yrs Employed ______

Home Address ______________ Street ______________ City ______________ Zip

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Do you currently have dental insurance? ☐ Yes ☐ No ☐ Not Sure
Does your Dental Insurance Plan include orthodontic coverage? ☐ Yes ☐ No ☐ Not Sure
Insured's Name ______________ Date of Birth ______________ Social Security # ______________
Insured's Employer ______________
Insurance Company ______________ Group No. ______________ Insured's ID # ______________
Insurance Co. Address ______________ Phone No. ______________

BENEFITS

Benefits of orthodontics include an improvement in the appearance of the teeth, improvement in the general function of the teeth, and improvement in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize **Dr. Sean K. Carlson** to perform a complete orthodontic evaluation.

Parent Signature: ______________ Date: ______________

CARLSON ORTHODONTICS
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