SMILES BY DESIGN
ORTHODONTICS

A

Patient Information

Name: _____ Preferred Name: _____
LAST FIRST

Date of Birth: _____/_____/_____ Gender: ☐ M ☐ F
YYYY MM DD

Home Address: _____
STREET CITY POSTAL CODE

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____ Work Phone: _____

Best way to reach you during business hours: ☐ Home ☐ Cell ☐ Work

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married

Please list other family members we have treated: _____

Other family members have had: ☐ Braces ☐ Jaw Surgery ☐ Other: _____

Person financially responsible: ☐ Self ☐ Other (If other, please list name, address and phone number below)

_____

Do you have orthodontic insurance coverage? ☐ No ☐ Yes (please specify): ☐ Self ☐ Other: _____

Patients Family Physician: _____ Patient's Family Dentist: _____

Whom may we thank for referring you to our office: _____

Medical History

Please check any of the following for which the patient has been treated:

- ☐ ADD or ADHD
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism
- ☐ Tuberculosis
- ☐ Endocrine (Hormonal)
- ☐ Epilepsy / Seizures
- ☐ Fainting & dizziness
- ☐ Growth Disorder
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ HIV / AIDS
- ☐ Latex Allergy
- ☐ Liver Problems
- ☐ Mononucleosis
- ☐ Nervous Disorders
- ☐ Rheumatic Fever
- ☐ Thyroid
- ☐ Kidney Problems
- ☐ Bleeding Disorders
- ☐ Bone Disorders
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Other: _____

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YES NO

- ☐ ☐ Are you in good health? If no, please specify:_____
- ☐ ☐ Do you have a history of major illness?_____
- ☐ ☐ Do you currently smoke?_____
- ☐ ☐ Have you ever smoked? If yes, number of days / years:_____
- ☐ ☐ Females: Are you pregnant and or trying to become pregnant?_____
- ☐ ☐ Are you taking any medications?_____
- ☐ ☐ Have you ever taken Bisphosphonates or medication for breast cancer?_____
- ☐ ☐ Have you been advised to take antibiotics before dental appointments?_____
- ☐ ☐ Do you have any allergies or drug sensitivity?_____

Dental History

What is your primary concern about your teeth and your smile? _____

Have you had a previous orthodontic exam or treatment? Please specify: _____

Please answer the following questions:

YES NO

- ☐ ☐ Have you had an injuries to the face, mouth or teeth?_____
- ☐ ☐ Do you have jaw clicking, cracking, locking or pain?_____
- ☐ ☐ Do you suffer from headaches or migraines?_____
- ☐ ☐ Do you clench or grind your teeth?_____
- ☐ ☐ Have you even sucked a thumb or finger? Until what age?_____
- ☐ ☐ Do you have any speech problems?_____
- ☐ ☐ Are you aware of any missing or extra teeth?_____
- ☐ ☐ Do you have any sore teeth?_____
- ☐ ☐ Are you a mouth breather?_____
- ☐ ☐ Have you had your tonsils or adenoids removed?_____

Other information you feel is important:_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to infrom this office. I also give my permission for clinical examination.

_____ _____

SIGNATURE DATE