ORTHODONTIC PATIENT INFORMATION

Welcome to our office!

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination. In order for Drs. Gillespie & Labs to thoroughly diagnose any condition, they must have accurate background and health information on which to base their decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response, where indicated. **Thank you.**

Patient's Name_____Age_____Birthdate_____Sex_____
Home address_____Home phone_____
Cell phone_____
City_____State_____Zip code_____
Patient's Employer_____Occupation_____phone_____
Person responsible for account_____Social Security #_____
Is Patient covered by insurance for orthodontic treatment? Yes No
If Yes, by which company?_____
Person to be contacted if patient cannot be reached:
Name_____Relationship_____Phone_____
Family Dentist_____Family Physician_____
Whom may we thank for this referral?_____

MEDICAL AND DENTAL HISTORY:

Present Health: Good Fair Poor Under treatment? Yes No
Specify:_____
Present Drugs or Medications?
Specify:_____
Has patient been under the care of a physician during the past two years other than for routine examination? Yes No
Birth Defects: Yes No
Specify:_____

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The following conditions are of interest to the orthodontist:
Has the Patient ever had:

Aids/HIV/TB	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Heart Disease	Yes	No
Anemia	Yes	No	Hearing Disorder	Yes	No
Blood Disease	Yes	No	Head or Face Injury	Yes	No
Bone Disorders	Yes	No	Rheumatic Fever	Yes	No
Diabetes	Yes	No	Endocrine Problems	Yes	No
Epilepsy	Yes	No	Emotional Problems	Yes	No

Comments:_____

Does the Patient:

1. Have allergies to:
   - Seasonal grasses Yes No
   - Food Yes No
   - Drugs Yes No
   - Other_____
2. Snore when sleeping? Yes No
3. Breathe through mouth? Seldom Sometimes Usually
4. Have frequent colds? Yes No
5. Have frequent sore throat or tonsillitis? Yes No
6. Have chewing or swallowing difficulty? Yes No

Has the Patient received medical treatment from allergist or ear, nose and throat specialist? Yes No

If yes: When_____By Whom_____

Tonsils removed_____Adenoids removed_____

Does the Patient have pain or clicking in the jaw joint? Yes No
Have any teeth been injured due to accidents to the mouth? Yes No
Has the Patient undergone speech therapy? Yes No
Thumb/finger sucking until age_____ Grinding of teeth? Yes No
Tongue thrusting Yes No
Lip biting or sucking Yes No Other habits? Yes No
Has the Patient had any unusual dental experience? Yes No

If Yes, specify:_____

Has Patient had previous orthodontic consultation or treatment? Yes No

Date:_____

Are there any other medical, dental or surgical problems? Yes No

Specify:_____

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Dental checkups: Twice a year Once a year Only if urgent Never
Date of last dental checkup_____Were teeth cleaned? Yes No
Is the patient aware of any orthodontic problem? Yes No
Patient's interest in orthodontic treatment:

Wants treatment Treatment if necessary Unwilling

Orthodontic consultation prompted by: Patient Dentist Other
What is the primary problem?_____
What is expected from orthodontic treatment?_____
Additional comments you wish to make:_____
Signature of individual completing this form:_____
Relationship to patient:_____Date:_____