

**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 \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Patient's occupation or school level \_\_\_\_\_ Business phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Home phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Business phone \_\_\_\_\_  
Cell 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? \_\_\_\_\_

**FAMILY STATUS:**

Siblings: None \_\_\_\_\_ Number of Brothers \_\_\_\_\_ Number of Sisters \_\_\_\_\_  
Father's Name \_\_\_\_\_ Living? Yes No  
Mother's Name \_\_\_\_\_ Living? Yes No  
Is Patient Adopted? Yes No  
Other family members with similar orthodontic condition?  
Father Mother Brother Sister Other Specify \_\_\_\_\_  
Parents' Marital Status \_\_\_\_\_  
Patient Living With: Mother Father Self Other \_\_\_\_\_

**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: \_\_\_\_\_  
Has Patient reached puberty (Menstruation, Hair)? Yes No

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 Mother Father

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: \_\_\_\_\_