RESTON ORTHODONTICS

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## PATIENT UNDER 18 YEARS OLD

Date_____

Patient's name_____
Last Middle First

Address_____
Street Zip City

Nickname_____ Birthdate_____ Social Security #_____

School_____ Sports/Hobbies_____

Parent or guardian name_____

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

## RESPONSIBLE PARTY INFORMATION

Name_____
Last Middle First

Residence_____
Street Zip City

Mailing Address_____
Street Zip City

Email Address _____

Home phone_____ Work phone_____ Cell/other phone _____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Social Security #_____ Birthdate_____ Work Phone _____

## DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's SSN #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes / No If yes:

Insured's Name_____ Insured's SSN #_____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

## EMERGENCY INFORMATION

Name of nearest relative not living with you_____Phone_____

Complete Address _____
Street Zip City

## MEDICAL HISTORY

Physician_____Date of Last Visit _____

Address_____Phone _____

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

Yes No Is the patient taking any medication?_____

Yes No Is the patient allergic to any medication?_____

Yes No History of a major illness?_____

Yes No Has the patient had any operations?_____

Yes No Ever been involved in a serious accident?_____

Yes No Have seen a physician in the last 12 months? Why?_____

*Female Patients only:*

Yes No Has menstruation started?_____

Circle any of the medical conditions below that the patient has had or currently has.

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

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

_____

_____

_____

## DENTAL HISTORY

General Dentist_____ Date of last visit _____

What concerns you most about your teeth? _____

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Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____

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Yes No What is the patient's attitude toward receiving orthodontic treatment? Positive? ____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Are you aware that some appointments will be during school hours? __

## BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. 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._____ to perform a complete orthodontic evaluation.

Signature:_____ Date: _____