PATIENT INFORMATION

Date_____

Patient's Name _____
Last First Middle Initial

Address _____
Street City State Zip

Nickname_____ Home Phone_____ Date of Birth _____ / _____ / _____

If patient is a minor, give parent's or guardian's name _____

Please list names of any siblings treated here _____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle Initial

Address _____
Street City State Zip

Home phone_____ Work phone _____ Mobile phone _____

Email address_____Relationship to Patient _____ _____

Social Security # _____ / _____ / _____ Date of Birth _____ / _____ / _____

Employer_____ Occupation_____

PRIMARY DENTAL INSURANCE

Insured's Name _____
Insured's Social Security # _____ / _____ / _____
Insured's Date of Birth _____ / _____ / _____
Insured's Employer _____
ID # _____
Group # _____
Insurance Company_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____

SECONDARY DENTAL INSURANCE (if applicable)

Insured's Name _____
Insured's Social Security **#** _____ / _____ / _____
Insured's Date of Birth _____ / _____ / _____
Insured's Employer _____
ID # _____
Group # _____
Insurance Company_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____

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 Does the patient require premedication for dental procedures?_____
Yes No Is the patient allergic to any medications? _____
Yes No Are patient's vaccinations up to date? _____
Yes No Does the patient have a history of a major illness? _____
Yes No Does the patient require any special considerations due to physical, psychological or emotional issues? _____
_____
Yes No Has the patient had any operations? _____
Yes No Has the patient ever been involved in a serious accident? _____
Yes No Other than routine visits, has patient been under the care of a physician in the last 12 months? Why? _____
_____

Please circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay Fever	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? _____

General Dentist _____ Date of Last Visit _____

Name of emergency contact _____
Phone _____ Relationship _____

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

DENTAL HISTORY

What concerns you most about your teeth? _____

Yes No Is patient presently in any dental pain?_____
Yes No Has patient ever experienced any unfavorable reaction to dentistry?_____
Yes No Has 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 patient's mouth sensitive to temperature? Where? _____
Yes No Is any part of patient's mouth sensitive to pressure? Where?_____
Yes No Do patient's gums bleed when brushed? _____
Yes No Does patient have any type of thumb or tongue habit?_____
Yes No Is patient a mouth breather? _____
Yes No Has patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is patient's attitude toward receiving orthodontic treatment?_____
Yes No Has anyone in your family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do patient's teeth or jaws ever feel uncomfortable upon waking in the morning?_____
Yes No Is patient aware of jaw clicking or popping?_____
Yes No Is patient aware of clenching teeth during the day? _____
Yes No Has patient ever been told that he/she grinds their teeth? _____
Yes No Does patient have "tension" headaches? _____
Yes No Has patient ever experienced chronic ringing in the ears? _____
If the patient is under age 16; height of parents? Mom_____ Dad_____
Yes No *Female Patients only:* Is there a possibility that patient is pregnant?

Yes No Are you aware that some appointments will be during school/work hours? _____
Please list some of patient's hobbies or interests _____
_____

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 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. Frydenlund to perform a complete orthodontic evaluation.

Signature: (parent's signature if patient is a minor) _____Date:_____

PLEASE DO NOT WRITE BELOW DOTTED LINE --- FOR OFFICE USE ONLY

MOLAR CLASS: I II III CUSPIDS: I II III OVERJET: _____ OVERBITE: _____ OPEN BITE:_____

MIDLINES — **MX: OK R L** / **MD: OK R L**

ALIGNMENT — **MX: CROWDING OK SPACE** / **MD: CROWDING OK SPACE**

8 7 6 5 4 3 2 1	**1 2 3 4 5 6 7 8**
e d c b a	**a b c d e**
e d c b a	**a b c d e**
8 7 6 5 4 3 2 1	**1 2 3 4 5 6 7 8**

TOOTH: JAW DISC. ? OK SPACED

X-BITE:

CARIES: SL M SV EST. TX

HYGIENCE: GOOD AVERAGE POOR