DELGADO ORTHODONTICS

PATIENT INFORMATION

Patient's Name: _____ M or F
Last *First* *Middle*

Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Adult Cell Phone: _____ DOB: _____ Age: _____

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

Whom may we thank for referring you to us? _____

Dentist: _____ Last Dental Cleaning: _____

School: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status: _____

Residence Address: _____

Mailing Address: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ DOB: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____

INSURANCE INFORMATION

Insurance #1

Policy Holder Name: _____ **DOB:** _____ SSN: _____

Insurance Company: _____ ID#: _____ Group #: _____

Insurance Company Address: _____ Insurance Company Phone: _____

Policy Holder's Employer: _____ Do you have dual coverage: ❑ No ❑ Yes

Insurance #2

Policy Holder Name: _____ SSN: _____

Insurance Company: _____ ID#: _____ Group #: _____

Insurance Company Address: _____ Insurance Company Phone: _____

Policy Holder's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Home Phone: _____ Cell Phone: _____ Relationship: _____

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

Updates *(date & initial)*: _____

DENTAL HISTORY

Patient's Name: _____

Reason for orthodontic examination: _____

List any injuries to the face, mouth: _____

Does patient have or has ever had...

Thumb/Finger Sucking Habit	❑ Yes	❑ No	Missing Permanent Teeth	❑ Yes	❑ No
Nail Biting Habit	❑ Yes	❑ No	Extra Permanent Teeth	❑ Yes	❑ No
Tongue Thrust Habit	❑ Yes	❑ No	Jaw Joint or Muscle Pain	❑ Yes	❑ No
Mouth Breathing Habit	❑ Yes	❑ No	Popping or Clicking Jaw	❑ Yes	❑ No
Habit of Leaning on Fist	❑ Yes	❑ No	Teeth Clenching/Grinding	❑ Yes	❑ No
Teeth Abscess or Gum Boils	❑ Yes	❑ No	Frequent Headaches or Neckaches	❑ Yes	❑ No
Previous Orthodontic Treatment	❑ Yes	❑ No	Migraines	❑ Yes	❑ No
Previous Orthodontic Consult	❑ Yes	❑ No	Family Member with Braces	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No	Tinnitus *(Ringing in ears)*	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No	Pre-Med Needed	❑ Yes	❑ No

Physician Name & Phone # _____

MEDICAL HISTORY

Is patient in good health?	❑ Yes	❑ No
Does patient have any history of major illness?	❑ Yes	❑ No
Does patient have a latex allergy?	❑ Yes	❑ No
Has patient ever been under care of physician for illness?	❑ Yes	❑ No

Nature of care: _____

Does patient have or has ever had...

Anemia	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Pre-med needed	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Bleeding Disorder	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No
Bone Disorder	❑ Yes	❑ No	Kidney Problem	❑ Yes	❑ No
Breathing Problem	❑ Yes	❑ No	Liver Involvement	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Nervous Disorder	❑ Yes	❑ No
Endocrine Problem	❑ Yes	❑ No	Pneumonia	❑ Yes	❑ No
Epilepsy	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Fainting	❑ Yes	❑ No	Speech Problem	❑ Yes	❑ No
Fever Blister/Cold Sore	❑ Yes	❑ No	Swallowing Problem	❑ Yes	❑ No
Heart Condition	❑ Yes	❑ No			

Has patient had a positive HIV or AIDS test or exposure to infected person? ❑ Yes ❑ No

Does patient have tendency to...

Colds: ❑ Yes ❑ No Sore Throats: ❑ Yes ❑ No Ear Infections: ❑ Yes ❑ No

Have the tonsils and/or adenoids been removed? *(what age: _____)* ❑ Yes ❑ No

Is there a possibility patient could be pregnant? ❑ Yes ❑ No

Are you currently taking or have been given oral or intravenous bisphosphonates for osteoporosis, osteopenia, or other uses such as: Fosamax, Actonel, Boniva, Reclast, Skelid, Didronel or Bonefos? *(how long: _____)* ❑ Yes ❑ No

List any drugs or medications now being taken and reasons: _____

LIST ANY ALLERGY OR DRUG SENSITIVITY _____

Signature (parent if patient is a minor): _____ Date: _____

Dr. Signature: _____ Date: _____