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Orthodontic & Dentofacial Orthopedics

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Member
American Association of
Orthodontists



Welcome! Our specialty is creating beautiful, healthy smiles. To do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.



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NEW PATIENT FORM (18 & UNDER)

PATIENT INFORMATION

Patient's Legal Name: _____ Preferred Name: _____

Today's date: ____ / ____ / ____ Birthdate: ____ / ____ / ____ Age: ____ Sex: M / F

Address: _____ City, State, Zip: _____

Phone Number: (____) _____ Email address: _____

Brothers/Sisters or Sons/Daughters (names/ages): _____

Hobbies/Interests: _____ School/ Grade: _____

Previous orthodontic consultation? Yes / No If so, when/where? _____

Previous orthodontic treatment? Yes / No If so, when/where? _____

Reason for seeking orthodontic treatment? _____

How did you hear about our office?: (Please mark all that apply)

- Dentist Referral Dental Office Staff Location Reputation
- Smiles Across the Bay Feldman Website Invisalign Website Invisalign Commercial
- I am a Former Patient Newspaper/Magazine Phone Book Coupon in the Mail
- Other: _____ Transferring Orthodontist _____
- I know a Feldman Orthodontic patient _____

Feldman Staff Member _____ (Name) Family Member _____ (Name)

RESPONSIBLE PARTY INFORMATION **REQUIRED**

Father's Name: _____ Marital Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home #: (____) _____ Work #: (____) _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ____ / ____ / ____

Employed By: _____ Occupation: _____ Years: _____

Email address: _____ Cell #: (____) _____

Mother's Name: _____ Marital Status: S / M / W / D

Address: _____ City, State, Zip: _____

Home #: (____) _____ Work #: (____) _____

Social Security: ____ - ____ - ____ Drivers License #: _____ Birthdate: ____ / ____ / ____

Employed By: _____ Occupation: _____ Years: _____

Email address: _____ Cell #: (____) _____

If divorce is involved, who is the Custodial Parent? _____

May patient information be released to the noncustodial parent? Yes / No

EMERGENCY INFORMATION

In case of emergency please contact _____ Phone () _____

Relationship to patient _____

DENTAL INFORMATION

How does the patient feel about wearing "braces/orthodontics"? _____

Does anyone else in the family need orthodontics? Yes / No If Yes, who? _____

Dentist's Name: _____ Does the patient receive regular checkups? Yes / No

Last Dental Exam: _____ Last Dental X-Rays: _____

Other Dental Specialists: _____

Have you been satisfied with past dentistry? Yes / No If No, please explain _____

Does the patient currently have, or have had any of the following? (please circle)

Thumb/finger Habit	Head/neck injury
Nail biting	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about? _____

MEDICAL INFORMATION

Physician's Name: _____ Patient's overall health: Excellent / Good / Poor

Is the patient allergic to anything (drugs/food/pollen): _____

Is the patient currently under medical care? Yes / No Where/When? _____

Is the patient currently taking medications? Yes / No Please list: _____

Has the patient ever been hospitalized? Yes / No Where/When? _____

Does the patient currently have, or have had any of the following? (please circle)

Adenoids removed	Drug history	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal/airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis A, B or C	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	Venereal disease

Is there any other medical information we should know about? _____

BENEFITS OF ORTHODONTICS

Your protected health information (PHI) may be used in connection with your treatment, payment on your account or health care operations. Our office will not disclose PHI except as otherwise required for treatment, diagnosis, and billing, the individual's rights and the practice's obligations.

Orthodontics is a service that provides an improvement in the appearance of the teeth, and general dental health. Teeth, gums and jaws are intricate body parts 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 state that I have read and understand the above, and have truthfully to best of my ability answered all of the questions on this form.

Patient/Parent Signature: _____ Date: _____

Thank you so much for taking your valuable time to fill out this form