MOUNTAINEER ORTHODONTICS
Specialists in Orthodontics

1-PATIENT INFORMATION

Today's date: _____ ( ) Male ( ) Female
Name: _____
last first middle
Nickname: _____ SS# _____
Birth Date: _____ Age _____
Height _____ Weight _____

Home Phone: (_____)_____
Cell Phone: (_____)_____
Home Address: _____
_____
city state zip
Email Address: _____

Employer: _____
Occupation: _____
Work phone: (_____)_____

General Dentist: _____
Referred By: _____

Patient Marital Status: (Circle one)
Single Married Separated Divorced
Widowed

2-SPOUSE INFORMATION

Name: _____
Address: _____
_____
city state zip
Home Phone #: (___) _____
Work Phone # (___) _____
Employer: _____
Occupation: _____
SS# : _____

3-RESPONSIBLE PARTY

Name: _____
Relationship to patient _____
Address: _____
_____
city state zip
Email Address: _____
Home Phone: (_____)_____
Work Phone: (_____)_____
Employer: _____
Occupation: _____
SS#: _____

4-PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ( ) Yes ( )No
Insurance Co. Name: _____
Insurance Co. Address: _____
_____
city state zip
Insurance Co. Phone #: (___)_____
Group# (Plan, Local, or Policy #):_____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birth Date: _____
SS#: _____
Policy Owner's Employer: _____

6-MEDICAL HISTORY (circle yes or no)

Yes	No	Abnormal bleeding
Yes	No	Allergies to any Drugs
Yes	No	Allergic to Latex or Metals
Yes	No	Allergic to Plastics
Yes	No	Anemia
Yes	No	Asthma
Yes	No	Bone Disorders
Yes	No	Cancer
Yes	No	Colds/Sore Throats
Yes	No	Congenital Heart Defects
Yes	No	Convulsions/Epilepsy
Yes	No	Diabetes
Yes	No	Endocrine Problems
Yes	No	Fainting or Dizziness
Yes	No	Handicaps/Disabilities
Yes	No	Hearing Impairment
Yes	No	Heart Trouble/Murmur
Yes	No	Hemophilia
Yes	No	Hepatitis
Yes	No	HIV+/AIDS
Yes	No	Kidney/Liver Problems
Yes	No	Liver Involvement
Yes	No	Major Illness
Yes	No	Nervous Disorders
Yes	No	Pneumonia
Yes	No	Rheumatic/Scarlet Fever
Yes	No	Seasonal Allergies
Yes	No	Tonsils/Adenoids Removed
		If yes, at what age: _____
Yes	No	Tuberculosis

List all drug allergies: _____
_____
Drugs now being taken/Reason: _____
_____
_____
Any other health information you would like us to know:
_____
_____

7- DENTAL HEALTH INFORMATION

Family Dentist: _____ **Date of last dental visit**: _____

Number of checkups per year: ( ) Once ( ) Twice ( ) Only if urgent ( ) Never
Have you had a previous orthodontic consultation or treatment? ( ) No ( ) Yes
Date (of consultation or treatment, if applicable): _____

History of:			If **yes**, mark those that apply:	Please explain
Tooth injury	( )No	( )Yes	( )Chipped ( )Broken ( )Lost	_____
Oral Disease	( )No	( )Yes	( )Decay ( )Ulcers ( )Sores	_____
Jaw Joint Noises	( )No	( )Yes	( )Right ( )Left ( )Both	_____
Grinding your teeth	( )No	( )Yes	( )During day ( )When sleeping	_____
Clenching your teeth	( )No	( )Yes	( )During day ( )When sleeping	_____
Bleeding gums	( )No	( )Yes	( )Usually ( )Sometimes ( )When brushing ( )Flossing	
Oral habits	( )No	( )Yes	( )Thumb/finger sucking ( )Tongue thrusting ( )Other	
Airway Problems	( )No	( )Yes	( )Mouth breathing ( )Other	
Speech therapy	( )No	( )Yes	( )Current ( )Past	

Why did you seek this consultation?

( ) To correct overbite	( ) Crowding	( ) Jaw dysfunction
( ) Eliminate facial pain	( ) Close spaces	( ) Improve facial proportions
( ) Improve general appearances	( ) Improve facial proportions	( ) Other: _____

Orthodontic consultation prompted by:
( ) Patient ( )Dentist ( )Hygienist ( )Friend ( )Relative ( )Other: _____

Future plans for other dental work? ( )Root Canal Therapy ( )Bridges ( )Crowns ( )Restorations ( )Cosmetic
If so please explain: _____

Tell us about you!
How do you feel about braces? _____
Any specific hobbies? _____
Active in any sports? _____

I certify that I have reviewed the above medical/dental history and it is accurate to my knowledge at this time. If there are any future changes in this information I will inform Mountaineer Orthodontics.

_____

Patient Signature **Date**