Bonney Lake ORTHODONTICS

Confidential Patient Information

Patient's Name:
Last First Middle

Address:
Street City State Zip

Home Phone: Birth date: Social Security:

School: Grade: Hobbies:

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

Whom may we thank for referring you to our office?

Names and ages of siblings:

Confidential Responsible Party Information

Name: Relationship to Patient:
Last First Middle

Address:
Street City State Zip

How long at this address: Home Phone: Cell Phone:

Email Address: Work Phone:

Best time of the day to be reached by phone: on weekdays and: on weekends:

Social Security #: Birth date: Marital Status:

Employer: Occupation: No. Years Employed:

Spouse's Information

Name: Relationship to Patient:
Last First Middle

Social Security #: Birth date: Cell Phone:

Employer: Occupation: No. Years Employed:

Dental Insurance Information

Policy Holder's Name: Member# **OR** Soc Sec. #:

Insurance Company: Group No.: Union Local No.:

Insurance Co. Address: Insurance Co. Phone:

Policy Holder's Employer:

Do you have dual coverage? No ☐ Yes ☐ If yes, please fill out boxes below

Policy Holder's Name: Member# **OR** Soc Sec. #:

Insurance Company: Group No.: Union Local No.:

Insurance Co. Address: Insurance Co. Phone:

Policy Holder's Employer:

Emergency Information

Name of nearest relative not living with you:

Complete Address:

Phone: Relationship:

I understand that credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Patient Health Information

What are your main reasons for seeking orthodontic treatment? _____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to your face, mouth, teeth, or chin? ☐ Yes ☐ No

List any musical instruments played: _____

Have your adenoids and / or tonsils been removed? ☐ Yes ☐ No

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had any pain/tenderness in the jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Do you see your dentist regularly for check-ups (i.e. at least every 6 months)? ☐ Yes ☐ No

Do you brush your teeth daily? ☐ Yes ☐ No

Do you floss your teeth daily? ☐ Yes ☐ No

Patient's dentist: _____ Date of last visit: _____

Patient's physician: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? (if child) ☐ Yes ☐ No

Has menstruation begun (girls)? ☐ Yes ☐ No

Please describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all the medications that you are currently taking: _____

Please list all the medications that you are allergic to: _____

Have you ever had any of the following medical problems?

Abnormal Bleeding	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Allergic to Plastic	☐ Yes ☐ No
Allergic to Latex / Metals	☐ Yes ☐ No	Hearing Impairment	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Handicaps / Disabilities	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
Any Hospital Stays	☐ Yes ☐ No	Any Operations	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Kidney / Liver Problems	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	HIV / AIDS	☐ Yes ☐ No
Convulsions / Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Congenital Heart Defect	☐ Yes ☐ No				

Please describe any medical problems you have had, current/past bisphosphonate use, and/or periodontal therapy:_____

_____

Do you have any of the following habits?		Clenching /Grinding Teeth	☐ Yes ☐ No	Tongue Thrust	☐ Yes ☐ No
Speech Problems	☐ Yes ☐ No	Lip Sucking / Biting	☐ Yes ☐ No	Nail Biting	☐ Yes ☐ No
Mouth Breather	☐ Yes ☐ No	Thumb / Finger Sucking	☐ Yes ☐ No	Tobacco Use	☐ Yes ☐ No

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature Date

Updates (date & initial) _____

Updates (date & initial) _____

Updates (date & initial) _____