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SAYRE ORTHODONTICS

PATIENT INFORMATION

Patient's Last Name	Patient's First Name	Patient's Preferred Name (Nickname)	M / F

Patient's DOB	Patient's Age	Patient's Email Address	Patient's Social Security #

Patient's Street Address	Patient's City, State, Zip	Patient's Home #	Patient's Cell #

Any other family members treated here? ☐ Yes ☐ No	If yes, who?

Other Sibling/Child Full Name	M / F	Sibling/Child DOB	Other Sibling/Child Full Name	M / F	Sibling/Child DOB

Patient's Dentist	Date of last dental cleaning

Whom may we thank for referring you to our office?	If patient is a minor, parent or guardian's name

RESPONSIBLE PARTY INFORMATION

Resp. Party's Last Name	Resp. Party's First Name	Resp. Party's Email Address	Relationship to Patient

Resp. Party's Street Address (if different from patient address)	Resp. Party's City, State, Zip	Resp. Party's Home #	Resp. Party's Cell #

How long at this address?	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Resp. Party's Social Security #

Previous Street Address (if less than 3 years at current address)	Previous City, State, Zip

Resp. Party's Employer	Resp. Party's Occupation	# Yrs at Employer	Resp. Party's DOB

Resp. Party's Spouse/Partner Name	Spouse/Partner Relationship to Patient	Spouse/Partner Employer	Spouse/Partner Occupation	# Yrs at Employer

Resp. Party's Spouse/Partner DOB	Spouse/Partner Social Security #	Spouse/Partner Work #	Spouse/Partner Cell #

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Last Name	Insured's First Name	Insured's Relationship to Patient	Insured's DOB

Insurance Company's Name	Insurance Company's Phone #	Insured's Member #	Insured's Group #

EMERGENCY INFORMATION (RELATIVE/FRIEND NOT LIVING WITH YOU)

Emergency Contact's Name	Emergency Contact's Street Address	City, State, Zip

Relationship to Patient	Emergency Contact's Home #	Emergency Contact's Cell #

Please continue on backside

Has an orthodontist been previously consulted? ☐ Yes ☐ No

Are antibiotics necessary for dental cleanings? ☐ Yes ☐ No

Has patient ever taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel or Boniva)? ☐ Yes ☐ No

List any drugs/things patient is allergic to or has a reaction to:

List any medications patient is currently taking:

Physician's Name:

What is your dentist's main orthodontic concern?

Is there any dental work needing to be completed prior to orthodontic treatment? ☐ Yes ☐ No

If yes, please explain:

Is patient under the care of a physician at this time? ☐ Yes ☐ No

If yes, please explain:

Indicate patient's feeling toward orthodontic treatment:

- ☐ Excited to get started
- ☐ Complacement
- ☐ Not Committed

Indicate patient's reasons for seeking orthodontic treatment:

- ☐ Esthetics
- ☐ Dental Function
- ☐ Overall Health

Please describe any orthodontic concerns and what you would like accomplished:

Personality Assessment (Please check all that describe patient)

☐ Nervous	☐ Outgoing	☐ Serious
☐ Calm	☐ Uncooperative	☐ Humorous
☐ Confident	☐ Sensitive	☐ Cooperative
☐ Shy	☐ Afraid	☐ Independent

Does patient have clicking, popping or pain in jaw joints? ☐ Yes ☐ No

If yes, which sides, since when and during what activity?

CHECK YES OR NO IF PATIENT CURRENTLY HAS OR HAS HAD:

Adenoids / tonsils abnormal	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Has patient reached puberty?	☐ Yes	☐ No
Adenoids / tonsils removed	☐ Yes	☐ No	Hemophiliac	☐ Yes	☐ No	Abnormal height or weight?	☐ Yes	☐ No
ADD / ADHD	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Is the patient adopted?	☐ Yes	☐ No
AIDS / HIV	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Does he/she know?	☐ Yes	☐ No
Allergy / sinus trouble	☐ Yes	☐ No	High / low blood pressure	☐ Yes	☐ No	Is the patient pregnant?	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Food allergies?	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Latex allergy?	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Nickel allergy?	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Muscle / joint problems	☐ Yes	☐ No			
Autism	☐ Yes	☐ No	Organ transplant	☐ Yes	☐ No	Is bite uncomfortable?	☐ Yes	☐ No
Bone disorders	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Any facial injuries?	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Physical disabilities	☐ Yes	☐ No	Trauma to the jaw?	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Psychiatric problems	☐ Yes	☐ No	Trauma to any teeth?	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No	Radiation / chemo / blood therapy	☐ Yes	☐ No	Clenching teeth?	☐ Yes	☐ No
Chronic cough	☐ Yes	☐ No	Respiratory problems	☐ Yes	☐ No	Grinding teeth?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatic / scarlet / yellow fever	☐ Yes	☐ No	Missing/extra permanent teeth?	☐ Yes	☐ No
Down syndrome	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No	Does the patient smoke?	☐ Yes	☐ No
Drug addiction	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Cheek, tongue or lip chewing?	☐ Yes	☐ No
Ear problems	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Finger / thumb / lip sucking?	☐ Yes	☐ No
Endocrine problems	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No	Fingernail habit?	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	TMJ problems	☐ Yes	☐ No	Mouth breathing?	☐ Yes	☐ No
Faintness / dizziness	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Difficulty breathing thru nose?	☐ Yes	☐ No
Fever blisters	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No	Snore while sleeping?	☐ Yes	☐ No
Headaches (frequent)	☐ Yes	☐ No	Whiplash	☐ Yes	☐ No	Speech problems?	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Wound healing problems	☐ Yes	☐ No	Strong gag reflex?	☐ Yes	☐ No

Please explain ANY medical or dental conditions not mentioned above:

PATIENT CONSENT

The undersigned hereby authorizes Dr. Jeremy Sayre and the staff of Sayre Orthodontics to take x-rays, study models, photographs and to an orthodontic examination in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in any medical status. I understand that when appropriate credit bureau reports may be obtained.

Patient or responsible party signature (if minor) _____ Date _____