

# PATIENT INFORMATION

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 Landline # | | | 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 Landline # | | | | 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 |
| Spouse/Partner DOB | | Spouse/Partner Social Security # | | | | Spouse/Partner Cell # | | | | | | Spouse/Partner Work # | | | |

**PRIMARY DENTAL INSURANCE INFORMATION**

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| --- | --- | --- | --- | --- | --- | --- |
| Subscriber's Last Name | Subscriber's First Name | | Subscriber's Relationship to Patient | | Subscriber's DOB | |
| Insurance Company's Name | | Insurance Company's Phone # | | Subscriber's Member # | | Subscriber'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 Landline # | | Emergency Contact's Cell # | |

Please continue on back

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 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  □Complacent  □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 | If adopted,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 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 patient is under 18 yrs old ) Date