

#  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**

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| --- | --- | --- | --- |
| 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