About You

Date of Exam:_____/_____/______

Name: ____

Last First Mi Mr Mrs Ms Dr

I prefer to be called:____________________________ ______Male _____Female Birthdate_____/_____/_____

Age:______ _____Single ____ Married____ Widowed ____Divorced

Address:____

Street City Zip

Home Phone: (____)_____________ Cell #: (____)______________Work Phone: (____)_____________ Ext: _____

Email Address: ___________________________________@_________________

Employer: _______________________________ How long there? _________ Occupation: __________________

Employer's Address: ____

City State Zip

Where and when are best times to reach you (Please **CIRCLE**) Morning Mid Day Afternoon Evening

Whom may we Thank for referring you? ____

Other family members seen by us: ____

Spouse Information

His / Her Name: ___________________________ Birth date: ______/______/_____

Employer: ________________________ Cell #: (____)______-_________Wk #: (____)______-________ Ext: ____

Emergency Information

Name of nearest Relative or Friend not living with you: __________________________ Relation:________________

Work #: (_____)___________________ Home #: (_____)_______-__________ Cell #: (____)______-___________

Orthodontic Insurance Information

Orthodontic Coverage: ___Yes ___No / Dental Coverage: ___Yes ___No / Ins. Company: _____________________

Group #:_________________ ID#: _______________________ Phone #: (_____)______-_________

Insurance Co. Address: ____

City State Zip

Insured's Name: _______________________ Relation: ____________ Insured's Birthdate: ______/_____/______

SS #: ________________________ Insured's Employer: ____

Employer's Address: ____

City State Zip

Medical History

Physician: ___________________ Date of Last Visit: _____/_____/_____

CIRCLE Yes or No to the following (If Yes, please fill in details):

Yes No Are you taking any medication? ____

Yes No Are you allergic to any medication? ____

Yes No Do you have a history of a major illness? ____

Yes No Have you had any major operations? ____

Yes No Have there been any injuries to the face, mouth, teeth or chin? ______________________

CIRCLE any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Epilepsy	Nervous Disorders	Tuberculosis
ADD/ADHD	Gastrointestinal Disorders	Herpes	Rheumatic Fever
Anemia	Handicap/Disability	Radiation/Chemotherapy	Sickle Cell
Asthma or Hayfever	Hearing Impairment	Kidney Problems	HIV
Cancer	Heart Murmur	Liver Problems	Low Blood Pressure
Congenital Heart Defect	Hepatitis/Liver problems	Mitral Valve Prolapse	High Blood Pressure
Stroke	Sinus Problems	Ulcers	Venereal Disease
Diabetes			

Are there any medical conditions we have not discussed that you feel we should be aware of? ________________

____

CIRCLE any allergic reactions to the following:

Yes	No	Asprin	Yes	No	Erythromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

Please list any other drugs / materials that you are allergic to:

____

Dental History

Dentist: ___________________________ Date of last visit: ____/____/_____

What concerns you most about your teeth? ____

CIRCLE Yes or No to the following questions:

Yes No Are you presently in any dental pain? Explain: ______________________________________

Yes No Have you ever experienced any unfavorable reaction to dentistry?
Explain: ____

Yes No Have you ever lost or chipped any teeth?

Yes No Is any part of your mouth sensitive to temperature or pressure?

Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?

Yes No Have you ever seen an orthodontist? If yes, who and when? ____________________________

Yes No Would you object to wearing orthodontic appliances (braces)?

Yes No Has anyone in your family received orthodontic treatment? If so, who? ______________________

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping? Explain:______________________________

Dental History continued:

Yes No Are you aware of clenching your teeth during the day?

Yes No Have you ever been told that you grind your teeth?
Yes No Do you have "tension" headaches?
Yes No Have you ever experienced chronic ringing in your ears?
Yes No Are you aware that some appointments will be during school/work hours? ___________________
Yes No Are you pregnant?
Yes No Do you have any missing or extra permanent teeth?
Yes No Do you have any speech problems?

Your current dental health is (Please CHECK): _____ Good ______ Fair ______ Poor

Are you happy with the way your smile looks? ____ Yes _____ No

Acknowledgment of Privacy Policy

I,__________________________________(please print first and last name), am aware that a copy of this office's Notice of Privacy Practices is available at request.

Benefits of Orthodontics

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr.Skelton to perform a complete orthodontic evaluation.

Signature: ____ Date: ____/____/____