



1254 East Central Avenue
 Miamisburg, Ohio 45342
 937-866-2449
 Fax 937-866-2449

Patient Information

Patients Name _____ Date _____

Last First Initial Preferred Name
 Birthday Age Sex School Grade

Address _____

City _____ Zip _____ Telephone () _____

Does child live with both parents? Yes No Mom Dad Other

Parent/ Patient _____

Employed By _____ Address _____

Family Dentist _____ Referred By _____

Names of other family members treated _____

Father's / Husbands Name _____ D.O.B. _____

Address (if different) _____ S.S.N. _____

Employed By _____ Business Address _____

Occupation _____ Time on Job _____ Bus. #() _____

Mother's / Wife's Name _____ D.O.B. _____

Address (if different) _____ S.S.N. _____

Employed By _____ Business Address _____

Occupation _____ Time on Job _____ Bus. #() _____

THIS SECTION MUST BE COMPLETED

Person Responsible for account _____ D.O.B. _____ S.S.N. _____

Address (if different) _____ Drivers Lic.# _____ State _____

Place of employment _____ Telephone () _____

Business Address _____ Dental Ins. Co. # _____

Bus. # () _____ Max Benefit \$ _____ (lifetime maximum if known)

I authorize the release of any necessary dental or medical records to Family Orthodontics for this patient. Records may be discussed with other health care providers and/or for educational purposes.

 Responsible Person

Patients Dental/Medical History

What are your primary concerns for today's visit? _____

Dentist Name: _____ Yes No Vision or Hearing Problems
Address: _____ Yes No Latex Allergies (gloves, balloons, band aids)
Phone: _____ Yes No Metals Allergies (jewelry, clothing snaps)
Yes No Seasonal Allergies
Yes No Other Allergies: _____

Please circle Yes or No

Yes No Patient is currently under care of a physician? Why? _____
Yes No Patient is or has taken bisphosphonates?
Yes No Patient is or has been treated for cancer, tumors or received radiation treatment and/or chemotherapy?
Yes No Is patient currently taking prescribed medication?
Medication: _____ Taken for: _____
Medication: _____ Taken for: _____
Yes No Are tonsils and adenoid present?
Yes No Had an unusual reaction to any drug? List: _____

If Patient is a Minor?

Yes No Is Child Adopted?
Yes No Is Child Aware of Adoption?
If Minor Female: (for Growth Purposes)
Yes No Has started Menstruation
Yes No Date of First Period: mo-_____/yr._____

If Minor Male:

 (for Growth Purposes)

Yes No Has Voice Changed? mo-_____/yr._____
Yes No Started Shaving? mo-_____/yr._____

Is there any information we should know about the patients health? _____

Now or in the past, have you had: (circle yes or no)

Yes No Hear Murmur, or Rheumatic Fever
Yes No Mitral Valve Prolapse
Yes No Pre-Medication is required before dental procedures
Yes No Anemia or Bleeding Disorders
Yes No Tuberculosis or Hepatitis
Yes No Diabetes
Yes No Epilepsy, Convulsions, Seizures, Fainting
Yes No Problems of the Immune System
Yes No Aids
Yes No Asthma, Breathing Problems, Snoring
Yes No Sinus problems, Frequent Colds, Cold Sores
Yes No Do you smoke or chew tobacco
Yes No Stomach Ulcers
Yes No Thyroid or Hormonal Imbalance
Yes No Rheumatoid or arthritic conditions
Yes No ADD/ ADHD
Yes No Nervous Disorder
Yes No Thumb/Finger Sucking Habit
Yes No Lip/ Nail Biting
Yes No Abnormal Swallowing Habit (Tongue Thrust)
Yes No Injury to Jaws or Teeth or Concussion
Yes No Severe Headaches or Facial Pain
Yes No Difficulty in Chewing or Jaw Opening or Closing

Please check all the sources that influenced you to choose Family Orthodontics.

- Doctor _____ referred me.
 My dentist's hygienist, assistant or staff member referred me
 I selected you from my insurance list of participation doctors
 _____ my relative/friend referred me
 I saw you in the Yellow Pages
 I saw your advertisement in (name source) _____
 I visited your website
 Other (please specify): _____

Office Comments _____

