Brookfield Orthodontics

PATIENT INFORMATION

Patient Name: ____ Date: __________________
First Last Nickname

Gender: *Male* *Female* *Other* ___________ Family Status: *Minor (under 18)* *Single* *Married* *Divorced* *Widowed*

Date of Birth: ______________________________ Social Security Number: _________________________________

Phone Home: (_____)____________________Cell: (_____)____________________Work: (_____)____________________

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work

Address: ____
Number Street Unit/Apartment Number

____
Town State Zip Code

Email: ____

If College Student: FT or PT School Name: __________________________City _________________ State ________

INSURED OR RESPONSIBLE PARTY

Information below is for: ☐ **Primary Subscriber** ☐ **Person responsible for payment** ☐ **Same as above**

Name:____

Gender: *Male* *Female* *Other* ___________ Family Status: *Single* *Married* *Divorced* *Widowed* *Child*

Date of Birth: ______________________________ Social Security Number: _________________________________

Phone Home: (_____)____________________Cell: (_____)____________________Work: (_____)____________________

Address: ____
Number Street Unit/Apartment Number

____
Town State Zip Code

Email: ____

DENTAL INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Dental Insurance Company:____

Policy Identification Number: _______________________________________ Group Number: _____________________

Policy Holder: _____________________________ DOB: _______________ Relation to Patient: ___________________

Insured Employer's Name: ____ Occupation: ________________________

Secondary Dental Insurance Company: ____

Policy Identification Number: _______________________________________ Group Number: _____________________

Policy Holder: _____________________________ DOB: _______________ Relation to Patient: ___________________

Insured Employer's Name: ____ Occupation: ________________________

REFERRAL INFORMATION

How did you hear about Brookfield Orthodontics? ____

Health History

Patient Name: ____

DENTAL HISTORY

General Dentist: ____ Date of last visit: ________________________
What concerns you most about your teeth? ____
Please circle Yes or No (if Yes, please fill in details)

Yes No Are you presently in any dental pain? ____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _________________________
Yes No Have your wisdom teeth been removed? ____
Yes No Have you lost or chipped any teeth? ____
Yes No Have there been any injuries to the face, mouth, or teeth? _______________________________
Yes No Is any part of your mouth sensitive to temperature? Where? ______________________________
Yes No Is any part of your mouth sensitive to pressure? Where? _________________________________
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 Does your jaw feel uncomfortable when you awake in the morning? _________________________
Yes No Are you aware of your jaw clicking or popping? ____
Yes No Are you aware of clenching your teeth during the day? ___________________________________
Yes No Have you been told that you grind your teeth? ____
Yes No Do you have "tension" headaches? ____

Yes No Has anyone in your family received orthodontic treatment? ________________________________
How did they feel about the result? ____
Yes No Are you aware that some appointments will be during the day? ____________________________
Yes No Have you ever seen an orthodontist? ____
If yes, name of doctor: ____________________________________ Date seen: _____________
What is your attitude toward receiving orthodontic treatment? ______________________________

MEDICAL HISTORY

Physician: ____ Date of last visit: ____________________________
Address:____Phone:_______________________________

Yes No Do you need to premedicate for dental appointments? _______________________________________
Yes No Are you taking any medications? ____
Yes No Are you allergic to any medications? ____
Yes No Any history of major illness? ____
Yes No Have you had any surgeries? ____
Yes No Any history of a serious accident? ____
Yes No Have you seen a physician in the last 12 months? Why? ______________________________________

Female Patients only:
Are you pregnant? Yes No Nursing? Yes No Taking Birth Control pills? Yes No

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

Anemia	Diabetes	HIV/AIDS	Sinus Problems
Arthritis	Dizziness	Kidney Disease	Sleep Apnea / CPAP
Artificial Heart Valves	Epilepsy	Liver Disease	Stroke
Artificial Joints	Excessive Bleeding	Low/High Blood Pressure	Thyroid Problems
Asthma	Fainting	Mental Disorders	TMJ/ Jaw Problems
Back Problems	Glaucoma	Mitral Valve Prolapse	Tobacco Habit
Blood Disease	Hay Fever	Nervous Disorders	Tuberculosis
Cancer	Head Injuries	Osteoporosis	Tumors
Chemical Dependency	Heart Disease	Pacemaker	Other___________________
Chemo/Radiation	Heart Murmur	Respiratory Problems	________________________
Circulatory Problems	Hepatitis	Rheumatic Fever	________________________

SIGNATURE

To the best of my knowledge, all of the preceding answers and information provided is accurate and complete. If there are any changes in health history, I will inform the doctor at the next appointment without fail.

____ _______________________________________
Signature of Patient/ Patient's Guardian Date