PT Orthodontics

www.PTortho.com

Patient Information

Patient's Name _____
Last First Name Prefer to be Called Middle Init.

Best Contact Phone: _____ Birthdate _____ Sex _____ Social Security # _____

Address _____
Street City State Zip

If patient is a minor, give parent's or guardian's name _____

How did you hear about us? (Check all that apply)

☐ Dentist ☐ Televison Commercial
☐ Friend ☐ Radio
☐ Internet (google, online search) ☐ Print Ad
☐ Other _____ ☐ Location Sign

General Dentist _____

Family members in or out of orthodontic treatment

_____

Responsible Party Information

Responsible Party or Guardian's Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____ Cell Phone Carrier _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

Orthodontic Insurance Information

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Insurance Company _____ Contract No. _____ Group No. _____

Insurance Co. Address _____

Subscriber's Employer _____ Subscriber's Birthdate _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Insurance Company _____ Contract No. _____ Group No. _____

Insurance Co. Address _____

Subscriber's Employer _____ Subscriber's Birthdate _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Please Complete the other side.

MEDICAL HISTORY

Are you in good health? ☐ yes ☐ no Explain: _____
Any major or unusual illnesses? ☐ yes ☐ no Explain: _____
Currently being treated by a physician? ☐ yes ☐ no Reason: _____
Currently taking medication? ☐ yes ☐ no Reason: _____
Allergies? ☐ yes ☐ no List: _____
Drug sensitivity? ☐ yes ☐ no List: _____

Please check if you have had any of the following:

☐ yes ☐ no Anemia
☐ yes ☐ no Blood Disease
☐ yes ☐ no Prolonged Bleeding
☐ yes ☐ no Jaundice
☐ yes ☐ no Rheumatic Fever
☐ yes ☐ no Scarlet Fever
☐ yes ☐ no Hepatitis
☐ yes ☐ no Are you in risk group for Aids
☐ yes ☐ no Glaucoma
☐ yes ☐ no Heart Problems
☐ yes ☐ no Tuberculosis
☐ yes ☐ no Diabetes
☐ yes ☐ no Endocrine Problems
☐ yes ☐ no Bone Disorders
☐ yes ☐ no Epilepsy
☐ yes ☐ no Herpes
☐ yes ☐ no Frequent Colds or Flu
☐ yes ☐ no Tonsillitis
☐ yes ☐ no Adenitis
☐ yes ☐ no Tonsils Removed: Age: _____
☐ yes ☐ no Adenoids Removed: Age: _____
☐ yes ☐ no Asthma
☐ yes ☐ no Mouthbreathing: While awake _____ While asleep _____

DENTAL HISTORY

☐ yes ☐ no Have you ever had any severe head or face injuries? ☐ yes ☐ no Explain: _____
☐ yes ☐ no Have you had a history of thumb sucking or finger sucking? _____ Stopped? _____ When? _____
☐ yes ☐ no Do you play any musical (wind) instruments? ☐ yes ☐ no What? _____
☐ yes ☐ no Have you consulted an orthodontist previously? _____
☐ yes ☐ no Have you had any previous orthodontic treatment? _____
☐ yes ☐ no Have any family members had orthodontic treatment? _____

Please check if there is a history of:

☐ yes ☐ no Clenching Teeth
☐ yes ☐ no Grinding Teeth
☐ yes ☐ no Muscular Soreness around Head & Neck
☐ yes ☐ no Headaches (more than normal)
☐ yes ☐ no Jaw Joint Soreness
☐ yes ☐ no Jaw Joint Clicking
☐ yes ☐ no Jaw Joint Popping
☐ yes ☐ no Ringing in the Ears

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Do you have any other concerns regarding your facial appearance? _____

Is there any other information that may be helpful? _____

_____

_____

_____

_____

Date: _____