Oaks Orthodontics

MAYS / BRUNO, DDS, MS

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Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY (Confidential)

Date _____

PATIENT INFORMATION

Patient's Name _____ Prefers to be called _____
Birthdate _____/_____/_____ Age _____ Sex _____ Social Security # _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____
If student, Name of School _____City _____ State _____
Sibling(s) Treated in this Office _____
Person to Contact in Case of Emergency_____ Phone ( ) _____
Parents' Marital Status: Single Married Widowed Divorced Separated
Father's Name _____ Home Phone ( ) _____ Work Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Mother's Name _____ Home Phone ( ) _____ Work Phone ( ) _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Email address _____
Whom May We Thank For Referring You to Our Office? _____

PERSON RESPONSIBLE FOR THIS ACCOUNT

First Name _____ MI _____ Last Name _____
Address _____ City _____ State _____ Zip _____
Occupation _____
Home Phone ( ) _____ Work Phone ( ) _____
Employer _____Years Employed _____Social Security # _____
Business Address _____ City _____ State _____ Zip _____
Relationship to Patient (Please circle) Parent Step Parent Legal Guardian Other
Person Responsible for Making Appointments: Name _____ Phone ( ) _____

ORTHODONTIC INSURANCE INFORMATION

Name of Insurance Company _____Policy # _____
Address _____ City _____ State _____ Zip _____
Policy Owner _____ Social Security # _____ Birthdate _____/_____/_ ___

PERSONAL INFORMATION

What is the main problem as you see it? _____
Has anyone in the family received orthodontic treatment? _____ Who? _____
How would you describe your child's temperament? _____
Is your child sensitive about the appearance of his/her teeth? _____
How does your child feel about wearing braces? _____
Patient's hobbies or interests _____

MEDICAL

Physician's Name _____ Approximate date of last medical examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N ever been hospitalized	Y/N tonsils removed	Y/N prolonged bleeding	Y/N mouth breathing
Y/N taking medication	Y/N adenoids removed	Y/N diabetes	Y/N snores when sleeping
Y/N allergic to medication	Y/N rheumatic fever	Y/N epilepsy	Y/N sounds "stuffy"
Y/N asthma	Y/N heart disease	Y/N hormone therapy	Y/N frequent sore throats
Y/N other allergies	Y/N heart murmur	Y/N emotional problem	Y/N abnormal growth problems
Y/N hepatitis	Y/N anemia	Y/N arthritis	

Updated

PLEASE EXPLAIN:

_____

_____

_____

GENETIC	**YES**	**NO**
Is the patient adopted?	Y	N
if so, does the patient know this?	Y	N
Has any member of the family had:		
A similar orthodontic condition?	Y	N
A similar facial appearance?	Y	N
A history of early or late puberty changes?	Y	N

PLEASE EXPLAIN:

_____

_____

_____

DENTAL

Dentist's Name _____ Approximate date of last dental examination _____

PLEASE CIRCLE IF APPLICABLE NOW OR IN THE PAST, AND EXPLAIN BELOW.

Y/N apprehensive about dental care	Y/N speech therapy	Y/N jaw joint pain
Y/N discomfort from teeth	Y/N injury involving teeth	Y/N jaw "tires" at mealtime
Y/N discomfort from gums	Y/N injury to either jaw	Y/N jaw catches when opening
Y/N previous orthodontic therapy	Y/N frequent clenching of teeth	Y/N jaw locks in closed position
Y/N frequent canker sores	Y/N wake up with sore teeth	Y/N facial pain
Y/N previous thumb/finger sucking	Y/N wake up with sore jaw	Y/N frequent headaches
Y/N thumb/finger presently active	Y/N jaw joint sounds	Y/N neck or shoulder pain

PLEASE EXPLAIN:

_____

_____

_____

Signature _____ Date _____