PATIENT INFORMATION

Please complete all the fields below.

POOLE ORTHODONTICS

CONFIDENTIAL PATIENT INFO

Patient's Name _____ Birth Date ____/____/_____ Gender ☐ F ☐ M

Address _____ City _____ State _____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Cell Phone Belongs to _____

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

Name and ages of siblings _____

Please list family members who have had orthodontic treatment _____

_____

Patient Interests/Hobbies _____

Whom may we thank for referring you to our office? _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you _____

Phone (_____) _____Relationship _____

RESPONSIBLE PARTY

Name _____
FIRST MIDDLE LAST

Relationship to Patient _____

Birth Date ____/____/_____

Marital Status _____

Email _____

Address _____

City _____ State _____ Zip _____

How long at this address? _____

Phone Numbers: Cell (_____)_____

Home (_____) _____Work (_____)_____

Employer _____

Occupation _____ No. Years Employed _____

Spouse's Name (or additional responsible party)

_____

Relationship to Patient _____

Birth Date ____/____/_____

Marital Status _____

Email _____

Address _____

City _____ State _____ Zip _____

Phone Numbers: Cell (_____)_____

Home (_____) _____Work (_____)_____

Employer _____

Occupation _____ No. Years Employed _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder's Name _____

Policy Holder's Date of Birth ____/____/_____

Insurance Company _____

ID # _____

Group # _____ Social Sec. # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____) _____

Policy Holder's Employer _____

SECONDARY INSURANCE

Policy Holder's Name _____

Policy Holder's Date of Birth ____/____/_____

Insurance Company _____

ID # _____

Group # _____ Social Sec. # _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone (_____)_____

Policy Holder's Employer _____

SIGNATURES

I authorize release of any information regarding this patient's orthodontic treatment to my dental and/or medical insurance company.

* _____

SIGNATURE OF PATIENT (or parent's signature if minor)

Date ____/____/_____

CONTINUED ON BACK →

MEDICAL HISTORY

YES NO Is the patient in good health? If No, list _____

YES NO To help us determine growth potential, if patient is between ages 8-18, have they reached puberty?

YES NO Are height and weight normal for age?

YES NO Have tonsils and/or adenoids been removed? At what age? _____

YES NO Frequent colds, sore throats, or ear infections?

YES NO Any history of major illness? If yes, list _____

YES NO Any allergies or drug sensitivity, including latex? If yes, list _____

YES NO Taking medication now? If yes, list _____

YES NO Is patient taking Bisphosphonates?

- ☐ Fosamax
- ☐ Actonel
- ☐ Zometa
- ☐ Prolia
- ☐ Boniva
- ☐ Reclast
- ☐ Other _____
- ☐ Denosumab

Under medical care now? Reason _____

Check any of the following for which the patient has been treated:

- ☐ Hepatitis
- ☐ Diabetes
- ☐ Arthritis
- ☐ Heart Trouble
- ☐ Convulsions
- ☐ Asthma
- ☐ Epilepsy
- ☐ Rheumatic Fever
- ☐ Emotional Problems
- ☐ Prolonged Bleeding
- ☐ Nervous Disorders
- ☐ Endocrine Problems
- ☐ Fainting
- ☐ Tonsillitis
- ☐ Brain Injury
- ☐ Tuberculosis
- ☐ Kidney
- ☐ Urinary Tract
- ☐ Glaucoma
- ☐ ADHD
- ☐ Aspergers
- ☐ Autism
- ☐ Anxiety

YES NO Does the patient have any special problems not listed above?

If yes, explain _____

DENTAL HISTORY

What are you and your dentist most concerned about? _____

Date of last dental exam _____ Patient's Dentist _____

YES NO Have there been any injuries to the face, mouth, or teeth? _____

YES NO Has the patient ever sucked their thumbs or fingers? Until what age? _____

YES NO Has patient ever had oral habits, such as lip biting or tongue thrusting? _____

YES NO Has the patient had any speech concerns or speech therapy? _____

YES NO Is the patient a mouth breather while asleep or awake? _____

YES NO Are you aware of any missing or extra permanent teeth? List _____

YES NO Has the patient had any orthodontic treatment performed previously?

If yes, please indicate type and extent of treatment _____

Other comments _____

Person filling out this form _____ Relationship to patient _____

SIGNATURES

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist if any changes in medical or dental health.

Signature _____ Date _____