VICKSBURG
ORTHODONTICS
ENHANCING THE SMILE CREATED IN YOU

WELCOME TO OUR OFFICE!

PATIENT INFORMATION

Patient's Name _____ Preferred Name_____ Sex_____

Mailing Address_____ ___ ____City _____ State_____ Zip_____

Birthdate_____ Age_____ SS#_____

Home Phone_____ Work Phone_____ Cell/Other Phone_____

Patient resides with: [ ] Mother [ ] Father [ ] Both [ ] Other_____ _____

Referred by _____ Do you know a patient currently in our practice? Whom _____

What would you like orthodontics to accomplish?_____

School_____ Grade_____ Interests_____

RESPONSIBLE PARTY INFORMATION

Name _____ Birthdate_____ _____ Age_____

Mailing Address_____City _____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell/Other Phone_____

SS#_____ Relationship to Patient_____ Email Address_____

Employer_____ Occupation_____ No. of Years Employed _____

Spouse's Name_____ Relationship to Patient_____

Birthdate_____ SS#_____ Phone #_____

Employer_____ Occupation_____ No. of Years Employed_____

DENTAL INSURANCE INFORMATION

Primary
Name of insured (Employee) _____ SS#/ID#_____ DOB_____

Insurance Co.___ _____Group # Ins. Phone #_____

Insurance Co. Address_____City _____ _____ State_____ Zip_____

Employer_____

Secondary
Name of insured (Employee) _____ SS#/ID#_____ DOB_____

Insurance Co._____Group #_____ Ins. Phone #_____

Insurance Co. Address_____City _____ State_____ Zip_____

Employer_____

EMERGENCY INFORMATION

Name of Nearest Relative Not Living with You _____ Phone #___ _____

Address_____City _____ State_____ Zip_____

MEDICAL HISTORY

Physician's Name_____ Phone_____

Have you experienced any health problems?	[ ] No	[ ] Yes	Explain:_____
Any major change in your health recently?	[ ] No	[ ] Yes	Explain:_____
Are you currently under physician's care?	[ ] No	[ ] Yes	Explain:_____
Are you currently taking medications?	[ ] No	[ ] Yes	List:_____
Are you allergic to any medications?	[ ] No	[ ] Yes	List:_____
Are you allergic to latex or metals?	[ ] No	[ ] Yes	List:_____
Have you received a blood transfusion?	[ ] No	[ ] Yes	Reason:_____
Have your tonsils or adenoids been removed?	[ ] No	[ ] Yes	When:_____

Heart Murmur	[ ] No [ ] Yes	Hepatitis	[ ] No [ ] Yes	Emotional Problems	[ ] No [ ] Yes
Heart Surgery	[ ] No [ ] Yes	Diabetes	[ ] No [ ] Yes	Frequent Headaches	[ ] No [ ] Yes
Rheumatic Fever	[ ] No [ ] Yes	Kidney Disease	[ ] No [ ] Yes	Nervous/Anxious	[ ] No [ ] Yes
Endocrine Disorders	[ ] No [ ] Yes	Liver Disease	[ ] No [ ] Yes	Cancer	[ ] No [ ] Yes
Prolonged Bleeding	[ ] No [ ] Yes	Tuberculosis	[ ] No [ ] Yes	Bone Disorders	[ ] No [ ] Yes
Anemia	[ ] No [ ] Yes	Bronchitis	[ ] No [ ] Yes	Growth Disorders	[ ] No [ ] yes
Blood Disease	[ ] No [ ] Yes	Asthma	[ ] No [ ] Yes	AIDS	[ ] No [ ] Yes
Developmental Disorder	[ ] No [ ] Yes	Epilepsy	[ ] No [ ] Yes	Herpes(fever blisters)	[ ] No [ ] Yes
Hives/Rash	[ ] No [ ] Yes	Fainting	[ ] No [ ] Yes	Tonsillitis	[ ] No [ ] Yes

Is there any other condition or problem that you think we should know about?_____

For Women:

Are you taking birth control pills?	[ ] No [ ] Yes	
Are you pregnant?	[ ] No [ ] Yes	Week #_____
Are you nursing?	[ ] No [ ] Yes	

Growth Information for Patients Under 18 Years of Age

Because growth can be an important factor in orthodontic treatment planning, your answers to the following questions are needed to aid in our selection of treatment alternatives:

Has your son or daughter reached puberty?	[ ] No [ ] Yes	
Girls - Has she started menstruation?	[ ] No [ ] Yes	When?_____
Boys - Has his voice changed?	[ ] No [ ] Yes	When?_____

Height_____ Do you feel growth is completed? [ ] No [ ] Yes

Father's Height_____ Mother's Height_____ Adopted? [ ] No [ ] Yes

Have either siblings or parents had orthodontic treatment? [ ] No [ ] Yes With whom?_____

DENTAL HISTORY

Dentist's Name:_____ **Phone**_____

Frequency of dental checkups: Twice a year [ ] Once a year [ ] Only if a problem exists [ ] Never [ ] Date of last visit_____

Is there any unfinished care to be completed with your dentist?	[ ] No [ ] Yes	Explain:_____
Are you frightened about dental treatment?	[ ] No [ ] Yes	Explain:_____
Have you had an unpleasant experience in a dental office?	[ ] No [ ] Yes	Explain:_____
Have you had any face or dental injuries?	[ ] No [ ] Yes	Explain:_____
Do you play any musical instruments?	[ ] No [ ] Yes	What instrument?_____
Do you play sports?	[ ] No [ ] Yes	Which sports?_____
Do you wear a mouth guard while playing sports?	[ ] No [ ] Yes	
Have you consulted an orthodontist previously?	[ ] No [ ] Yes	Whom?_____
Have teeth (either primary or permanent) been removed?	[ ] No [ ] Yes	
Have you had any previous orthodontic treatment?	[ ] No [ ] Yes	With whom?_____
Are you satisfied with prior treatment?	[ ] No [ ] Yes	Explain:_____
Do your gums bleed?	[ ] No [ ] Yes	
Is there a history of thumb or finger sucking?	[ ] No [ ] Yes	Stopped?_____

Please check if there is a history of:

[ ] Tongue thrust [ ] Clenching/grinding teeth [ ] Lip sucking/biting [ ] Nail biting

[ ] Nursing bottle habits [ ] Headaches (more than normal) [ ] Excessive snoring [ ] Ringing in the ears

[ ] Muscular soreness around head & neck [ ] Jaw joint soreness [ ] Jaw joint popping/clicking

[ ] Speech problems (If so, which sounds_____) [ ] Mouth breathing: Awake_____ Asleep_____

Is there any other information that may be helpful?_____

I, the undersigned, have given the above dental and medical information, reviewed it, and find it accurate. If there are any changes to this record, I will inform this practice.

Signature_____ **Date**_____

FOR DOCTOR'S USE ONLY. PREMEDICATE FOR BANDING / DEBANDING [ ] YES [ ] NO