Med Alert:____

DATE____________________
Comp No# ______________
Family No# ______________

DR. LINTS
ORTHODONTIC PATIENT INFORMATION

WELCOME TO OUR OFFICE;

The following information is requested to enable us to give you the best consideration of your orthodontic problem during your initial examination in our office. In order for the orthodontist to thoroughly diagnose any condition, he must have accurate background and health information on which to base his decisions. This information, important for our records and your health, is confidential. Please circle the appropriate response where indicated.

PATIENT INFORMATION

Name: ____
Last First Init.

Birthdate:________________ Age:__________ Sex:________

Address:____

City:____

State:______________________________Zip:________

Home Phone:__________-______________________

Cell Phone: ____

Email: ____

FAMILY STATUS

Patient Living With:____

Father's Name:____

Mother's Name:____

Siblings: None _________Number Brothers ________Number Sisters

Family Dentist:____

Referred by:____

Family Phys.:____

Eligible for any financial subsidy or benefits? Y____ N____

DENTAL INSURANCE INFORMATION:

Name of Policy Holder:____

Employer:____

Birthdate:__________________ Relation to Patient:______________

Soc. Security No.:____

Name of Ins. Co.:____

Address:____

Group No.______________ Contract No.______________

Elig. Date ________________ Lifetime Max________________

Co Pay ________________ Last Date Checked______________

Date____________________ Remaining Balance____________

Primary ________________ Secondary________________

PERSON RESPONSIBLE FOR ACCOUNT

Name:____

Address: ____

City: __________________________ State:______ Zip:________

SSN: ____

Home Phone: ______________ Work Phone:______________

Cell Phone: ____

Employer: ____

Email:____

Marital Status:____

Relationship to Patient: ____

OTHER PARENT INFORMATION

Name:____

Address: ____

City: __________________________ State:______ Zip:________

SSN: ____

Home Phone: ______________ Work Phone:______________

Cell Phone: ____

Employer: ____

Email:____

Marital Status:____

Relationship to Patient: ____

SECOND DENTAL INSURANCE CARRIER INFORMATION

Second Policy Holder:____

Employer:____

Birthdate:________________ Relation to Patient:______________

Soc. Security No.:____

Name of Ins. Co.:____

Address:____

Group No.______________ Contract No.______________

What Type of Reminders Would You Like to Receive?

- ❑ Phone ____
- ❑ Email ____
- ❑ Text messages Cell Phone # ______________________

Carrier (i.e. Verizon, AT&T, etc.) ______________________

PATIENT'S MEDICAL & DENTAL HISTORY

Patient Name:______________________________

HAS THE PATIENT EVER HAD: (PLEASE CIRCLE)

Acquired Immuno-Deficiency Syndrome	Bone Disorders	Epilepsy	Hepatitis (type__________)
Anemia	Cancer (Any form)	Glaucoma	Respiratory Problems
Arthritis	Diabetes	Head or Face Injury	Rheumatic Fever
Asthma	Emotional Problems	Hearing Disorder	Venereal Disease(s)
Blood Disease (Any Bleeding Disorders)	Endocrine Problems	Heart Disease (Any Kind)	Blood Transfusion
❑ NONE OF THE ABOVE		Pregnant	date__________

ANY OTHER MEDICAL INFORMATION RELEVANT (Please Comment): ______________________________

Present Health: Good Fair Poor

Does Patient have Any Birth Defects? Yes No

Under Treatment:______________________________

Specify: ______________________________

Presently Taking Medication: Yes No

Patient Reached Puberty (Menstruation, Hair) Yes No

Specify: ______________________________

Has Patient Been Under Physician's Care During Past Two Years Other than Routine Exams? Yes No

1. Do you have allergies to: Seasonal grasses__________________ Food__________________
   Drugs__________________ Other__________________
   Latex__________________
2. Do you have problems wearing earrings or jewelry?__________ Allergic to nickel or any metal?__________
3. Snore when sleeping? YES NO
4. Breath through mouth? Seldom Sometimes Usually COMMENTS:__________________
5. Have frequent colds? Yes No
6. Have\frequent sore throat or tonsillitis? Yes No
7. Does patient smoke? Yes No Do Parents Smoke? Mother Father Spouse
8. Having chewing or swallowing difficulty? Yes No

Has the patient received medical treatment from allergist or ear, nose and throat specialist?

Yes No If YES: When __________________ By Whom __________________

Tonsils removed __________________ Adenoids removed __________________

_____ Does the patient have pain or clicking in jaw joint? Yes No When Started__________________

_____ Have any teeth been injured due to accidents or blows to the mouth? Yes No Date __________________

_____ Are you currently taking Bisphosphonates? Yes No

Has the patient received or been requested to receive speech correction? Yes No Date __________________

Thumb sucking until age __________ Grinding of teeth Yes No

Finger sucking until age __________ Tongue thrusting Yes No

Lip-biting or sucking Yes No Other habits (Comment) __________________

Has the patient had any unusual dental experiences? Yes No

Specify:______________________________

Does the patient wear Contact Lenses? Yes No

Are there any other medical, dental or surgical problems not covered above? Yes No

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT:

Frequency of Dental Checkups: Twice A Year Once A Year Only If Urgent Other ________ Date of Last Checkup ________

Were the patient's teeth cleaned? Yes No Are There Any Teeth That Need Fillings? Yes No Uncertain

Is The Patient Aware Of Any Orthodontic Problem? Yes No Ever Seen Another Orthodontist? Name __________ Date________

Any x-rays taken at another orthodontist? Yes No Date of x-rays taken:__________________

Are There Other Family Members With Similar Orthodontic Condition? Yes No Have They Received Treatment Yes No

If Treatment Indicated Patient Would: Want Treatment Accept Treatment Be Unwilling But Go Along Not Participate

Orthodontic consultation prompted by: Patient Dentist Mother Father Spouse Sibling Physician Friend Other (specify): __________________

Why did the patient seek this consultation? ______________________________

What is the CHIEF COMPLAINT? ______________________________

What is expected from orthodontic treatment? ______________________________

Additional comments you wish to make: ______________________________

____

SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM: ______________________________

RELATIONSHIP TO PATIENT __________________ TODAY'S DATE __________________