Oak Park Dentistry for Children & Orthodontics
A Professional Corporation

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Orthodontics and Dentofacial Orthopedics

PATIENT HISTORY - Adult (Confidential)

Date _____

PATIENT INFORMATION

Patient Name _____ Prefer to be called _____
Birthdate _____/_____/_____ Age _____ Sex _____ Social Security # _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____ E-mail Address _____
If student, Name of School, College _____City _____ State _____
Family / Friends Treated in this Office _____
Person to Contact in Case of Emergency_____ Phone ( ) _____
Occupation _____ Work Phone ( ) _____
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 ( ) _____ Cell Phone ( ) _____
Employer _____ Work Phone ( ) _____
Business Address _____ City _____ State _____ Zip _____
Person Responsible for Making Appointments: Name _____ Phone ( ) _____

ORTHODONTIC INSURANCE INFORMATION

Name of Insurance Company _____Policy # _____
Address _____ City _____ State _____ Zip _____
Policy Owner _____ Social Security # / ID # _____ Birthdate _____/_____/_____
Subscriber Relationship to Patient_____ Insurance Co. Phone ( )_____

PERSONAL INFORMATION

What is the main problem as you see it? _____
_____
_____
Are you sensitive about the appearance of your teeth? _____
Are you sensitive about the appearance of any facial features? (nose, chin, lips, etc.) _____
How do you feel about wearing braces? _____
_____
Has anyone in the family received orthodontic treatment? _____ Who? _____
What do you consider the main benefits of orthodontic correction?
Cosmetic ____ Functional ____ Psychological/Emotional ____ Other _____

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
- taking medication
- allergic to medications
- asthma
- other allergies
- hepatitis

Y/N
- other respiratory problems
- mouth breathing
- rheumatic fever
- heart disease
- heart murmur
- anemia

Y?N
- prolonged bleeding
- diabetes
- arthritis
- epilepsy
- hormone therapy
- psychological counseling

Updated

PLEASE EXPLAIN: _____

_____

_____

_____

_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

_____

_____

_____

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
- discomfort from teeth
- discomfort from gums
- previous orthodontic therapy

- frequent canker sores
- previous thumb/finger sucking
- thumb/finger presently active

Y/N
- speech therapy
- injury involving teeth
- injury to either jaw
- frequent clenching of teeth

- wake up with sore teeth
- wake up with sore jaw
- jaw joint sounds

Y/N
- jaw joint pain
- jaw "tires" at mealtime
- jaw catches when opening
- jaw locks in closed position

- facial pain
- frequent headaches
- neck or shoulder pain

PLEASE EXPLAIN:

_____

_____

_____

_____

_____

Signature _____ Date _____