

SECONDARY DENTAL INSURANCE

Orthodontic Coverage: Yes No
 Insurance Co. Name: _____
 Insurance Co. Phone: (_____) _____
 Insurance Co. Address: _____

 Group # (Plan, Local, or Policy): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: _____ / _____ / _____
 Policy Owner's SS #: _____
 Policy Owner's Employer: _____

ADDITIONAL DENTAL INSURANCE

Orthodontic Coverage: Yes No
 Insurance Co. Name: _____
 Insurance Co. Phone: (_____) _____
 Insurance Co. Address: _____

 Group # (Plan, Local, or Policy): _____
 Policy Owner's Name: _____
 Relationship to Patient: _____
 Policy Owner's Birthdate: _____ / _____ / _____
 Policy Owner's SS #: _____
 Policy Owner's Employer: _____

PERSONAL HABITS HISTORY

Are any of the following habits present?

| | | |
|-----|----|--------------------------|
| Yes | No | Clenching/grinding teeth |
| Yes | No | Lip sucking/biting |
| Yes | No | Mouth breather |
| Yes | No | Nail biting |
| Yes | No | Thumb/finger sucking |
| Yes | No | Tongue thrust |

Has puberty begun (boys): Yes No
 Has menstruation begun (girls): Yes No
 Physician _____
 * * * * *

Please list other family members we have treated.

DENTAL HISTORY OF PATIENT

What are the main concerns that you would like orthodontics to accomplish? _____

Have there been any injuries to the face, mouth, teeth, or chin? Yes No
 Have adenoids or tonsils been removed? Yes No
 Are there any missing or extra permanent teeth? Yes No
 Is there any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No
 Are there any speech problems? Yes No
 Are teeth brushed on a daily basis? Yes No
 Are teeth flossed on a daily basis? Yes No
 Dentist: _____

 Name _____
 Date of Last Visit: _____ / _____ / _____

MEDICAL HISTORY OF PATIENT

Have any of these conditions been present:

| | | |
|-----|----|---------------------------|
| Yes | No | Abnormal bleeding |
| Yes | No | Allergic to latex/metals |
| Yes | No | Asthma |
| Yes | No | Cancer |
| Yes | No | Congenital heart defect |
| Yes | No | Convulsions/epilepsy |
| Yes | No | Diabetes |
| Yes | No | Handicaps/disabilities |
| Yes | No | Heart murmur |
| Yes | No | Hepatitis |
| Yes | No | HIV+/AIDS |
| Yes | No | Hospital stays/operations |
| Yes | No | Kidney/liver problems |
| Yes | No | Thyroid problems |

Please discuss any medical problems: _____

Please list any medications taken currently: _____

Please list any known drug allergies: _____

Please list any other allergies: _____

