

# TAYLOR ORTHODONTIC SPECIALISTS

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) Nickname \_\_\_\_\_  M  F  
Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
(Mth) (Day) (Yr)  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Patient's Physician \_\_\_\_\_ Dentist \_\_\_\_\_  
Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_  
Brothers/Sisters \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_  
(Name/Birthdate) (Name/Birthdate) (Name/Birthdate)

## PARENT OR GUARDIAN INFORMATION:

Father's Name \_\_\_\_\_ Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Address \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Business Phone \_\_\_\_\_  
Marital Status of Parents:  Single  Married  Widowed  Separated  Divorced  
Person Responsible for Account \_\_\_\_\_  
If Dental Insurance, Name and Carrier \_\_\_\_\_ Policy No. \_\_\_\_\_  
Insured Name \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_  
Social Security No. of person covered \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Orthodontic Benefits  Y  N  Unsure  
Whom may we thank for referring you? \_\_\_\_\_  
What is your primary reason for seeking orthodontic treatment? \_\_\_\_\_

## MEDICAL/DENTAL INFORMATION

### MEDICAL HISTORY (Check yes or no and fill in blanks where required)

Have tonsils and/or adenoids been removed? .....  No  Yes  
Any allergies or sensitivity (drug, metal, jewelry)? If yes, list \_\_\_\_\_  No  Yes  
Taking medication now? If yes, list ( Drug(s) and Purpose(s) \_\_\_\_\_  No  Yes  
Under medical care now? Reason \_\_\_\_\_  No  Yes  
Has patient reached puberty? Girls (Menstruation) Boys (Voice change, facial hair) .....  No  Yes  
(Women) Is the patient pregnant? .....  No  Yes  
Check any of the following for which the patient is or has been treated:  
 Hepatitis  Rheumatic Fever  Emotional Problems  Fainting  HIV / AIDS  
 Diabetes  Asthma  Prolonged Bleeding  Convulsions  Abnormal Blood Pressure  
 Arthritis  Epilepsy  Nervous Disorders  Brain Injury  Kidney Problems  
 Heart Trouble  Heart Murmur  Endocrine Problems  Tuberculosis  Liver Problems  
Does the patient have any special problems or major illness not listed above? Explain \_\_\_\_\_  No  Yes

### DENTAL HISTORY (Check yes or no and fill in blanks where required)

Date of last dental exam? \_\_\_\_\_ Is work completed? .....  No  Yes  
Have there been any injuries to the face, mouth, or teeth? If yes, list \_\_\_\_\_  No  Yes  
Have you ever had oral habits, such as lip biting or tongue thrusting? If yes, list \_\_\_\_\_  No  Yes  
Do you have any dental discomfort including TMJ? .....  No  Yes  
Do you have any speech problems? .....  No  Yes  
Are you a mouth breather while asleep or awake? .....  No  Yes  
Are you aware of any missing or extra permanent teeth? .....  No  Yes  
Has an orthodontist been consulted previously? .....  No  Yes  
Has anyone in the family been previously treated in our practice? .....  No  Yes  
What are you and your dentist most concerned about? \_\_\_\_\_  
Other Comments \_\_\_\_\_

Signature: \_\_\_\_\_ Dr. Initials \_\_\_\_\_ Date \_\_\_\_\_