A B C

Date________________

PATIENT INFORMATION AND HEALTH HISTORY C

Thank you for completing this information before your first visit. It is a confidential part of our patient records.

Exam date ________________ Exam time ________________

Smith Orthodontics
GERALD L. SMITH DDS, MSD
104 West Cascade Way, Suite 100
Spokane, WA 99208
(509) 467-6535 · FAX 467-4507

Patient Information

Patient's last name ________________ First name ________________ M.I. ______ Phone ________________

Mailing address ________________ City ________________ State ______ Zip ________________

School ________________ Grade ________ Date of birth ________ Age ______ Sex: ❒ M ❒ F

Other family members under treatment at this office? ________________

What is the nature of your dental concern? ________________

Whom may we thank for referring you? ________________

Responsible Party Information

Last name ________________ First name ________________ Marital status ________________

Residence ❒ Same as patient **or** ________________ City ________________ State ______ Zip ________________

Mailing address ❒ Same as patient **or** ________________ City ________________ State ______ Zip ________________

How long at this address? ________________ Home phone ________________ Work phone ________________

Previous address (if less than 3 years) ________________ City ________________ State ______ Zip ________________

Social security # ________________ Date of birth ________________ Relationship to patient ________________

Employer ________________ Occupation ________________ No. of years employed ________________

Spouse's last name ________________ First name ________________ Relationship to patient ________________

Social security # ________________ Date of birth ________________ Work phone ________________

Employer ________________ Occupation ________________ No. of years employed ________________

Family Information (Child Patient)

We request the following information so we are able to communicate effectively with the people involved in your treatment.

With whom does the patient live? ________________

Are the parents married? ❒ yes ❒ no Separated? ❒ yes ❒ no Divorced? ❒ yes ❒ no Remarried? ❒ yes ❒ no

Parent Information

Patient's Father

Last name ________________ First name ________________

Residence ❒ Same as patient **or** ________________ City ________________ State ______ Zip ________________

Home phone ________________ Work phone ________________

Patient's Mother

Last name ________________ First name ________________

Residence ❒ Same as patient **or** ________________ City ________________ State ______ Zip ________________

Home phone ________________ Work phone ________________

Other persons we should know about (i.e. stepparents)

Last name ________________ First name ________________

Relationship to patient ________________ Home phone ________________ Work phone ________________

Residence ❒ Same as patient **or** ________________ City ________________ State ______ Zip ________________

MINOR PATIENT GROWTH INFORMATION

Height of: Patient ______ Father ______ Mother ______

Have any members of the family had orthodontic treatment? If yes, who and where

____

Dental History

Patient's dentist ______________________________

Date of last cleaning ______________________________

Has all dental work/fillings been completed ❑ yes ❑ no

Check if the patient has or has had:

❑ extra teeth ❑ gum disease or infection

❑ missing teeth ❑ teeth sensitive to hot, cold, or sweets

Check all that apply to patient:	Yes	If yes, please explain
Prior orthodontic evaluation		Date:
Prior orthodontic treatment		Date:
History of thumb or finger sucking		
Is patient sensitive about their habit?		
Breathes with mouth open		
Extracted teeth		
Had a severe injury to the head, face, or teeth		Date:
Treatment by periodontist, endodontist, or oral surgeon		
Negative or resistant feelings about braces		
Dissatisfied with the appearance of their teeth		

Temporomandibular Joint

Check all that apply to patient:	Yes	If yes, please explain
Treatment for a jaw joint problem		
History of clenching or teeth grinding		
Jaw joint (TMJ) makes noise or hurts when moving		
Pain in or around the teeth, ears, temples, or cheeks		
Bite feels uncomfortable or unusual		
Frequent headaches		

Transfer Orthodontic Patient

Patient's orthodontist ______________________________

Address ______________________________

Date of last adjustment ______________________________

Has the patient:

Had unusual growth rates ❑ yes ❑ no

Inherited family facial or dental characteristics ❑ yes ❑ no

Reached puberty ❑ yes ❑ no

(generally signalled by voice changing in boys and menstrual cycle in girls)

Medical History

Patient's physician ______________________________

Check all that apply to patient:	Yes	If yes, please explain
Current or past medical conditions		List:
Taking any medication(s)		List:
Allergies		List:
Unfavorable reaction to medications		
Any surgery or hospitalizations		
Emotionally, mentally or physically challenged		

Please check any of the following which the patient has or has had:

❑ Adenoids removed at age______
❑ Tonsils removed at age______
❑ AIDS or HIV positive
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bleeding problems
❑ Bone disorders
❑ Cleft lip
❑ Cleft palate
❑ Diabetes
❑ Dizziness
❑ Epilepsy or convulsions
❑ Fainting
❑ Glaucoma
❑ Hearing problems
❑ Heart disease
❑ Heart murmur
❑ Hepatitis
❑ High blood pressure
❑ Hyperactivity
❑ Kidney problems
❑ Latex allergy
❑ Liver problems
❑ Malignances, tumors, cancers
❑ Prosthetic joint (replacement)
❑ Radiation therapy
❑ Rheumatic/Scarlet fever
❑ Speech problems
❑ Thyroid or hormonal imbalance
❑ Tuberculosis
❑ Wears contact lenses

Are there any other dental or medical concerns we should know about?

____

____

Signatures

This information is complete and accurate. If any information changes, I will notify Dr. Smith's office immediately. I authorize the release of my records (child's records) to my insurance company, physician, or dentist as deemed necessary in the professional judgment of my dentist.

____
Patient signature/guardian signature of minor patient date

I understand that where appropriate credit reports may be obtained.

____
Patients signature/guardian signature of minor patient date