



Clermont Orthodontic Specialists

Today's Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____
(first) (middle) (last)

Birthdate: _____/_____/_____ Age: _____ Male Female

Address: _____ Social Security #: _____ - _____ - _____

How long at current address? _____

E-mail: _____@_____

Hm #: (_____) _____ Cell#: (_____) _____ Wk#: (_____) _____

Single Married Divorced Widowed Separated

General Dentist: _____ Office Number: _____

Date of last visit for dental checkup?: _____ School: _____

Whom may we thank for referring you? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
(first) (middle) (last)

Birthdate: _____/_____/_____ Age: _____ Male Female

Single Married Divorced Widowed Separated

Address: _____ Social Security #: _____ - _____ - _____

Hm #: (_____) _____ Cell#: (_____) _____ Wk#: (_____) _____

Relation to Patient: _____

Employer: _____ Occupation: _____

Employer's Address: _____

How many years with current employer? _____

SPOUSE INFORMATION

His/ Her Name: _____
(first) (middle) (last)

Relation to Patient: _____ Birthdate: _____/_____/_____

Employer: _____ Occupation: _____

Employer's Address: _____

Social Security #: _____ - _____ - _____ Phone Number: (_____) _____

PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage: Yes No

Policy Holder's Name: _____ Birthdate: ____/____/____

Social Security #: _____ - _____ - _____ Group #: _____

Insurance Co. Name: _____ **EMPLOYER:** _____

Claims Address: _____

Ins. Co. Phone #: (_____) _____

MEDICAL HISTORY

What are the main concerns that you would like us to focus on? _____

Your current physical health is:	GOOD	FAIR	POOR
Are you currently under the care of a physician?:		YES	NO
Are you taking any prescription/over-the-counter drugs?:		YES	NO
Please list: _____			
Has puberty begun?		YES	NO
For Women:			
Has menstruation begun?:		YES	NO
Are you using a prescribed method of birth control?:		YES	NO
Are you pregnant?:		YES	NO
Are you nursing?:		YES	NO

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y	N	Heart Problems (Murmur, pacemaker...)	Y	N
ADD/ADHD	Y	N	Hemophilia	Y	N
Any hospital stays	Y	N	High/ Low Blood Pressure	Y	N
Any operations	Y	N	Hearing Impairment	Y	N
Anemia	Y	N	Hepatitis	Y	N
Artificial Bones/Joints/Valves	Y	N	HIV + / AIDS	Y	N
Asthma/ Arthritis	Y	N	Kidney/ Liver Problems	Y	N
Blood Transfusion	Y	N	Lupus	Y	N
Cancer/ Chemotherapy	Y	N	Mitral Valve Prolapse	Y	N
Chicken Pox	Y	N	Mumps	Y	N
Congenital Heart Defect	Y	N	Measles	Y	N
Convulsions/ Epilepsy/ Seizures	Y	N	Psychiatric Problems	Y	N
Diabetes	Y	N	Polio	Y	N
Diphtheria	Y	N	Radiation Treatment	Y	N
Difficulty Breathing	Y	N	Rheumatic/ Scarlet Fever	Y	N
Drug/ Alcohol Abuse	Y	N	Sinus Problems	Y	N
Emphysema	Y	N	Severe / Frequent Headaches	Y	N
Endocrine	Y	N	Shingles	Y	N
Fever Blisters/ Herpes	Y	N	Sickle Cell Disease/ Traits	Y	N
Glaucoma	Y	N	Tuberculosis (TB)	Y	N
Handicaps/ Disabilities	Y	N	Ulcers/ Colitis	Y	N
Heart Attack/ Stroke	Y	N	Venereal Disease	Y	N

PLEASE LIST ANY SERIOUS MEDICAL CONDITION(S) THAT YOU HAVE EVER HAD?

PLEASE LIST ANY ALLERGIES: _____

DENTAL HISTORY

Have you ever...

Had or been evaluated for orthodontic treatment?	Y	N
Had a serious/difficult problem associated with any previous dental work?	Y	N
Had any injuries to the face, mouth, teeth, or chin?	Y	N
List any musical instruments played? _____		
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)?	Y	N
Do you like your smile?	Y	N
Gums ever bleed?	Y	N
Do you see a general dentist regularly?	Y	N
Have speech problems?	Y	N
Had tonsils or adenoids removed?	Y	N
Do you have any missing or extra permanent teeth?	Y	N
Do you brush your teeth daily?	Y	N
Floss daily?	Y	N
Ever taken Phen-Fen (Redux, Pondimin)?	Y	N
Ever taken Fosamax, or any other bisphosphonate?	Y	N
Has this office ever rendered treatment to any of your family?	Y	N
Are you aware that some appointments may/ will infringe upon work or school time?	Y	N
Do you smoke or use tobacco in any form?	Y	N
Do you require pre-medication before any dental procedure?	Y	N

Have you ever experienced any of the following?

Clenching/Grinding Teeth	Y	N	Nursing Bottle Habits	Y	N
Lip Sucking/ Biting	Y	N	Speech Problems	Y	N
Mouth Breather	Y	N	Thumb/ Finger Sucking	Y	N
Nail Biting	Y	N	Tongue Thrust	Y	N

In order to accommodate our current and future patients accordingly we ask that you give us a 24 hour notice for any cancelled appointment.

By signing below, patient/responsible party acknowledges the above information as being correct and agrees to notify The Brace Place of any changes that may occur.

I, _____, hereby authorize Dr. Alan M. Wong to evaluate my (self, son/daughter) _____ for possible orthodontic treatment.

Signed: _____ Date: _____