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Patient Information

Patient's Name ______________________________ ______ (Last, First, Middle, Sex)

Address ______________________________ (Street, City, State, Zip)

Home Phone ____________________ DOB ____________________

Parent/Guardian Email Address ______________________________

Whom may we thank for referring you to our office? ______________________________

Is there a staff member at Evans Orthodontics who is primarily responsible for you choosing our office? YES NO

If so, who? ____________________ Appointment Date ____/____/____

Who is accompanying child to appointment ____________________ Relationship ____________

Guardian Information

FATHER'S INFORMATION ❑ **STEPFATHER** ❑ **GUARDIAN**

Father's Name ______________________________ (Last, First, Middle) DOB ____________

Address ______________________________ Marital Status ____________

Home Ph # ____________ Work Ph # ____________ Cell Ph # ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

MOTHER'S INFORMATION ❑ **STEPMOTHER** ❑ **GUARDIAN**

Mother's Name ______________________________ (Last, First, Middle) DOB ____________

Address ______________________________ Marital Status ____________

Home Ph # ____________ Work Ph # ____________ Cell Ph # ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

Person Responsible for Account

Name ______________________________ Relationship to Patient ____________

Billing Address ______________________________ (Street, City, State, Zip)

How long at this address ____ Home Ph. ____________ Work Ph. ____________ Cell Ph. ____________

Social Security # ______________________________ DOB ____________

Employer ____________ Occupation ____________ No. Years Employed ____________

I authorize Evans Orthodontics to obtain a credit report. (This may allow more payment options.)

Signature ______________________________

Emergency Information

Name of nearest relative or friend not living with you. ______________________________

Phone ____________________ Relationship ____________________

Orthodontic Insurance Information

Primary Policy Holder's Name ______________________________ DOB ____________

Insurance Co. ____________ Phone # ____________ Soc. Sec. # / ID# ____________

Insured's Employer ______________________________ Group # ____________

Secondary Policy Holder's Name ______________________________ DOB ____________

Insurance Co. ____________ Phone # ____________ Soc. Sec. # / ID# ____________

Insured's Employer ______________________________ Group # ____________

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records only. Naturally they will be considered confidential and will become part of your permanent dental record.

Height__________ Weight__________ Occupation__________

Father's Height__________ Mother's Height__________

Siblings' Names__________ Ages__________

Physician's Name__________

Dentist's Name__________ Date of Last Visit__________

What is your estimation of your general health? (circle one) Good, Fair, Poor

What is your main reason for seeking orthodontic care?__________

____

If any of the following are answered yes; please give a brief explanation.

1. Has Dr. Evans treated others in your family? YES NO
2. Has an orthodontist been consulted previously? YES NO
3. Have you ever experienced any unfavorable reactions from previous dental or medical care? YES NO
   Please explain:__________
4. Have you had a toothache recently? YES NO
5. Is there any history of thumb-sucking, finger-sucking, lip biting or nail biting? YES NO
6. Have you visited a dentist within the past year? YES NO
7. Do you think your teeth are affecting your general health in any way? YES NO
8. Are you worried about receiving orthodontic treatment? YES NO
9. Do you have difficulty chewing your food? YES NO
10. Do you have any cheek biting problems? YES NO
11. Do you have sensitive teeth? YES NO
12. Do you have bleeding gums or periodontal "gum" disease? YES NO
13. Have you ever had sores in the mouth or on the lips that are slow to heal? YES NO
14. Do you have difficulty in opening your mouth widely? YES NO
15. Do you have any speech problems? YES NO
16. Do you grind your teeth at night? YES NO
17. Do you now have or have you ever had sinus trouble? YES NO
18. Have you ever chipped a tooth or had a serious blow to the teeth? YES NO
19. Have you ever had any injury to your face or jaws? YES NO
20. Have you ever been treated for "TMJ"? (jaw joint problems) YES NO
21. Do your jaw joints ever click or pop? YES NO
22. Has your jaw ever "locked" open or closed? YES NO
23. Have you been examined by your physician within the last year? YES NO

24. Are you being treated for any condition by a physician now? YES NO
What is the condition?________________________________

25. Have you been taking any medicines within the past year? YES NO
Please list them here:________________________________

26. Has there been any change in your general health in the past year? YES NO

27. Have you lost or gained weight in recent months? YES NO

28. Have you ever been hospitalized or seriously ill? YES NO

29. Have you ever had surgery (an operation)? YES NO

30. Have you ever had a blood transfusion? YES NO

31. Have you ever had X-ray or surgery treatment for a tumor, growth, or other conditions anywhere including your head, mouth or on your lips? YES NO

32. Are you frequently exhausted, fatigued or ill? YES NO

33. Have you ever had any kind of the following diseases or conditions:

Diabetes (sugar disease)	YES	NO	Hepatitis or Jaundice (yellow skin & eyes)	YES	NO
Tuberculosis or Polio	YES	NO	Chicken Pox	YES	NO
Measles	YES	NO	Mumps	YES	NO
Sexually Transmitted Disease	YES	NO	Immune Disorder or HIV	YES	NO
Heart Attack or Stroke	YES	NO	Rheumatic Fever	YES	NO
Ulcers	YES	NO	Scarlet Fever	YES	NO
Epilepsy	YES	NO	Glaucoma	YES	NO

34. Have you ever had painful or swollen joints? YES NO

35. Do you currently have a heart murmur or did you ever take the diet drug Phen-Fen? YES NO
If yes, do you need antibiotic premedication before routine dental work? YES NO

36. Do you have or have you ever had any heart trouble or chest pain on exertion? YES NO

37. Do you have high blood pressure? YES NO

38. Do you bruise easily or bleed for a long time when you cut yourself? YES NO

39. Do you have any blood disorder such as anemia (thin blood)? YES NO

40. Do your ankles ever swell? YES NO

41. Do you have a persistent cough? YES NO

42. Do you have to urinate frequently, either during the day or night? YES NO

43. Are you thirsty much of the time? YES NO

44. Has a doctor ever said you had kidney or bladder disease or infection? YES NO

45. Has a doctor ever said you had liver disease? YES NO

46. Have you ever experienced an unusual reaction to any of the following drugs:

Penicillin	YES	NO	Iodine	YES	NO
Augmentin	YES	NO	Sulfa Drugs	YES	NO
Ceclor	YES	NO	Banthine or Atropine	YES	NO
Erythromycin	YES	NO	Other Medicine____________	YES	NO

47. Have you ever experienced an unusual reaction to a dental anesthetic? ("Novocaine injection") YES NO

48. Do you have asthma? YES NO

49. Do you have hay fever or other environmental allergies (to food, cat's fur, dust, etc.) ? YES NO

50. Do you have hives or skin rash? YES NO

51. Do you have an allergy to latex or balloons? YES NO

52. Do you have an allergy to nickel or other metals? YES NO

53. Do you have any numbness in any part of your body? YES NO

54. Has any part of your body ever been paralyzed? YES NO

55. Do you ever have fits or convulsions? YES NO

56. Do you have a tendency to faint? YES NO

57. Do you have frequent, severe headaches or sinus problems? YES NO

58. Have you ever been diagnosed with or treated for sleep apnea? YES NO

59. Do you have a snoring problem that you are aware of? YES NO

60. Do you consider yourself to be a nervous person? YES NO

61. Do you often feel unhappy and depressed? YES NO

62. Are you easily upset or irritated? YES NO

63. Do you have any behavior disorders or mental health problems? YES NO

64. Women -- Are you pregnant at this time? YES NO

65. Women -- Are you in or have you passed the menopause (change of life)? YES NO

66. Women -- Have you had a hysterectomy or ovariectomy? YES NO

67. Have you ever or are you now taking a drug of the class Bisphosphonate or Diphosphonates for osteoporosis? Examples: Fosamax, Boniva, Actonel, Zometa or Reclast YES NO

68. Is there any other information about your dental or medical health history you feel we should know about? YES NO

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I grant permission for Evans Orthodontics to release pertinent information to dental offices.

Adult Patient or Parent Signature______________________________ Date______________

I have reviewed this history. Dr. Signature ______________________________ Date______________

Updates (date and initial) ____

FORM# PH1