UTAH ORTHODONTIC CARE

Today's date: _____

NEW PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____ Sex: M F

I prefer to be called: _____ Marital Status: _____ Spouse's Name: _____

Patient's Address: _____City:_____State:_____Zip Code: _____

SSN #:_____ Email Address: _____

Home Phone: _____ Cell Phone: _____Cell Carrier: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Emergency Contact: _____ Phone: _____ Relationship to You: _____

Please state what you feel is wrong with your teeth: _____

How did you hear about our office? _____

Name of Dentist: _____ Last Seen: _____Reason:_____

Name of Dental Office: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Policy Holder's Name: _____SSN#:_____DOB_____

Insurance Company Name: _____

ID#_____

Secondary Policy Holder's Name: _____SSN#:_____DOB_____

Insurance Company Name: _____

ID#_____

If you would like to tell us more about why you are considering braces, please use the box below:

DENTAL HISTORY Now or in the past, have you had:

□ yes □ no Any teeth removed for any reason?
□ yes □ no Supernumerary (extra) or congenitally missing teeth?
□ yes □ no Chipped or otherwise injured primary (baby) or permanent teeth?
□ yes □ no Jaw fractures, cysts or mouth infections?
□ yes □ no Periodontal problems, bleeding gums, bad taste or mouth odor?
□ yes □ no Thumb, finger or sucking habit? Until what age_____?
□ yes □ no Abnormal swallowing habit (tongue thrusting)?
□ yes □ no History of speech problems?
□ yes □ no Mouth breathing habit, snoring or difficulty in breathing?
□ yes □ no Tooth grinding, jaw clenching clicking or locking?

MEDICAL HISTORY Now or in the past, have you had:

□ yes □ no Congenital heart defect?
□ yes □ no Abnormal bleeding?
□ yes □ no Diabetes?
□ yes □ no Cancer, tumor, radiation treatment or chemo?
□ yes □ no Heart murmur?
□ yes □ no Handicaps/Impairment?
□ yes □ no Convulsion/Epilepsy?
□ yes □ no Asthma?
□ yes □ no Hemophilia?
□ yes □ no HIV/AIDS?
□ yes □ no Vision, hearing, tasting or speech difficulties?
□ yes □ no Mental health disturbance or behavioral problems?

Check allergies or reactions to any of the following:

□ Aspirin
□ Penicillin or other antibiotics
□ Latex (gloves, balloons)
□ Vinyl, Acrylic or Animals
□ Ibuprofen (Motrin, Advil)
□ Tylenol
□ Sulfa Drugs
□ Metals (jewelry)
□ Foods (specify)

□ yes □ no Any pain in jaw or ringing in the ears?
□ yes □ no Treatment for "TMD" or "TMJ" problems?
□ yes □ no Aware of loose, broken or missing restorations (fillings)?
□ yes □ no Have adenoids or tonsils been removed?
□ yes □ no Any problems with wisdom teeth?
□ yes □ no Is patient sensitive or self-conscious about teeth?
□ yes □ no Ever had a prior orthodontic exam or treatment?

How often do you brush? _____
How often do you floss? _____

□ yes □ no Do you smoke or chew tobacco?
□ yes □ no Operations or surgeries?

Describe:

_____
_____

WOMEN

□ yes □ no Are you pregnant?

□ yes □ no Do you anticipate becoming pregnant?

Are there any other medical conditions that we Should be aware of? _____
_____
_____

Please list any medication, nutrient supplements, Herbal medications or nonprescription medicine Being taken by the patient.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

I have read and understand the above questions. I will not hold my treating doctor or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will be sure to inform this practice. Furthermore, I consent to an orthodontic examination and if necessary, orthodontic records which include photos, impressions and x-rays

Print Name: _____
(Patient)

Signed: _____ Date Signed: _____