

## DENTAL HISTORY

Any injuries to the face, mouth, or teeth? Yes No

\_\_\_\_\_

History of thumb or finger habit? Yes No

Until what age? \_\_\_\_\_

Does the patient have speech problems? Yes No

Describe \_\_\_\_\_

Is the patient a mouth breather? Yes No

While awake? Yes No

While asleep? Yes No

Missing or extra permanent teeth Yes No

\_\_\_\_\_

Have you previously consulted an orthodontist? Yes No

Previous orthodontic treatment? Yes No

Has either parent had orthodontic treatment? Yes No

Do you require antibiotics prior to dental appts. Yes No

Do you now or have you ever experienced pain/  
discomfort in you jaw joint (TMJ/TMD)? Yes No

Grinding or clenching habit? Yes No

Cheek biting? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## INSURANCE INFORMATION

### PRIMARY INSURANCE

Patient name: \_\_\_\_\_

Subscribers name: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ Group#: \_\_\_\_\_

Birthdate of subscriber: \_\_\_\_\_

### SECONDARY INSURANCE

Subscribers name: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ Group#: \_\_\_\_\_

Birthdate of subscriber: \_\_\_\_\_

I understand that I am responsible for payment for services rendered and also responsible for paying any copayment and deductions that my insurance does not cover.

\_\_\_\_\_  
Signature Date

### Doctor's comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_  
2. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_  
3. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_