

INITIAL EXAM INFORMATION

Date: _____ Account #: _____
(Office Use Only)

Patient's Name: _____
(First & Nickname) (Middle) (Last)

Address: _____
(Number & Street) (City) (State) (Zip)

Age: _____ Birth date: _____ Adopted: _____ Phone: _____

Sex: _____ Occupation/School: _____ Grade: _____

Responsible Party: _____ Relationship to Patient: _____

Address: _____
(Number & Street) (City) (State) (Zip)

S.S.#: _____ Drivers Lic #: _____
(Required) (State – License Number)

Employer: _____ Work Phone #: _____

Spouse's Name: _____ Work Phone #: _____

Employer: _____ Work Phone #: _____

Patient's Dentist: _____ City: _____ Phone: _____

Date of Last Cleaning: _____

E-mail address: _____

Hobbies: _____

List any relatives in treatment at More-Smiles Orthodontics: _____

Have you ever consulted with an Orthodontist before? Yes No

Who may we thank for referring you to our office: _____

Medical History

(Circle "any" of the following that the patient has or had previously)

Asthma/Allergies
Hepatitis
Syphilis/Gonorrhea
AIDS/HIV positive
High Blood Pressure
Arthritis
Heart Murmur
Chest Pain/Angina
Rheumatic Fever
Heart Attack

Heart Pacemaker
Anemia
Stroke
Bronchitis
Emphysema
Sinus Problems
Bleeding Disorder
Ulcers
Artificial Joint
Cancer

Thyroid Disease
Kidney Problems
Diabetes
Seizures/Epilepsy
Tuberculosis
Psychiatric Disorder
Anesthesia Problems
Steroid Medication
Mononucleosis

Medical History continued...

- Allergies? Yes No What? _____
- Mouth Breather? Yes No
- Speech Problems? Yes No Explain: _____
- Finger/Thumb Sucker? Yes No At what age? _____
- Any Surgeries? Yes No What? _____
- Tonsils/Adenoids removed? Yes No
- Pregnant? Yes No Due Date: _____
- Any injuries to mouth? Yes No List: _____
- Any ear problems? Yes No What? _____

Is the patient under the care of a physician for any reason or taking any medication?

Physician: _____ Medications: _____

TMJ Questionnaire

(Please complete the following questions ONLY if you have any form of jaw problem.)

- Yes No Has the patient ever been treated for TMJ?
- Yes No Has the patient noticed limitations in opening the mouth?
- Yes No Frequent Headaches?
- Yes No Has the jaw ever locked open/closed or slipped out of place?
- Yes No Any grinding/clenching or the teeth?
- Yes No Any tranquilizers, muscle relaxants or anti-depression being taken?
- Yes No Does the pain interfere with normal day-to-day activities?

Insurance Information

(Please complete the following **ONLY** if you have **orthodontic insurance**)

Primary Insurance: _____

Policy Holder: _____ S.S.#: _____ Birth date: _____

Place of Employment: _____ Group Number: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

Insurance Company Address: _____
(No. and Street) (City) (State) (Zip)

Signature: _____
(Patient/Parent/Guardian)

FOR DOCTOR'S USE ONLY
