PATIENT HISTORY

DATE:______________________

• PATIENT

Name____
First Middle Last

Male ❑ Female ❑ Age________ Birthdate________________ • Phone #______________________ Cell #______________________

Address____ City____________________ zip____________

Email Address________________________ ❑ Single ❑ Married ❑ Divorced ❑ Children____________________

Employed by____ • Position____________________

Address____ • Phone #____________________

• SPOUSE

Name____ • Phone #____________________
First Middle Last

Employed by____ • Position____________________

Address____ • Phone #____________________

• INSURANCE INFORMATION

Insured's Employer Name____

Insurance Company Name____ Group #____________________

Insured's Name________________________ • SS # or Ins. I.D. #____________________ D.O.B.____________

Chief reason for seeking treatment____

Patients Dentist____
City Phone #

Friends or Relatives treated by Dr. Roth____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

May we contact you by email and/or cell phone? ❑ Email Address____________________ ❑ Cell Phone #____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

______ Individual refused to sign

______ Communication barriers prohibited obtaining the acknowledgement

______ An emergency situation prevented us from obtaining acknowledgement

______ Other (Please specify)

PATIENT PROFILE:

Are you concerned with the appearance of your smile? ______

Why do you think orthodontic treatment is needed? ______

Are there any other family members with a similar condition? ______

Has there been any prior orthodontic treatment or appliances? ______

Is there any information that would help us better treat you? ______

MEDICAL HISTORY:

Now or in the past, has the patient had:

YES	NO	DON'T KNOW	
❑	❑	❑	Allergy to latex?
❑	❑	❑	Allergy to antibiotics? List ______
❑	❑	❑	Allergy to any medications? List ______
❑	❑	❑	Heart Disease or blood pressure issues? ______
❑	❑	❑	Cancer, tumor, radiation or chemotherapy? ______
❑	❑	❑	Arthritis? ______
❑	❑	❑	Endocrine or thyroid problems? ______
❑	❑	❑	Eating Disorder? ______
❑	❑	❑	Environmental allergies, hay fever, asthma? ______

MEDICATIONS: List all medications: ______

DENTAL HISTORY:

Have there been any accidents or trauma to the teeth or face? ______

Are there any missing teeth? ______

Are there any other dental conditions or problems that we should be aware of? ______

FOR OFFICE USE ONLY

MEDICAL HISTORY UPDATE OR CHANGES:

Comments: ______

Signed: ______ Date: ______

MEDICAL HISTORY UPDATE OR CHANGES:

Comments: ______

Signed: ______ Date: ______

FOR OFFICE USE ONLY **DATE:** ______

TMJ ______ Gingiva ______ Habits ______

Hygiene ______ Fractures ______ Heredity ______

				E	D	C					C	D	E				
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
Right																	Left
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
				E	D	C					C	D	E				

CL: ______ ML ______ X-Bite ______

CO-OJ ______ CR-OJ ______ Slide ______

OB ______ Profile ______

Crowding : Mx ______ Mn ______

Probable • Ext ______ Non-Ext ______ Borderline ______

Treatment Time ______ Fee Range ______

Problems ______

NT ______ Charge ______ PD ______

NOTES