PATIENT HISTORY

DATE:_____

• PATIENT

Name_____
First Middle Last

Male ❑ Female ❑ Age_____ Birthdate_____ • Phone #_____

Address_____ • _____
City zip

School_____ • Grade_____

• PARENTS OR GUARDIANS

Mr. Dr.

Mrs. Ms._____
First Middle Last

❑ Single
❑ Married
❑ Separated
❑ Divorced

Father's Name_____ • Date of Birth_____ • Employed by_____

Business Address_____ • Phone #_____ Cell #_____

Email Address_____

Mother's Name_____ • Date of Birth_____ • Employed by_____

Business Address_____ • Phone #_____ Cell #_____

Email Address_____

• INSURANCE INFORMATION

Insured's Employer Name_____

Insurance Company Name_____ Group #_____

Insured's Name_____ • SS # or Ins. I.D. #_____ D.O.B._____

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 child's 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 your child? _____

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? _____

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			
Right	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8 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_____

Advised

- ❑ Delay treatment until more permanent teeth erupt.
- ❑ Treatment not indicated at this time.
- ❑ Orthopedic phase I treatment.
- ❑ Full treatment.
- ❑ Limited treatment.

Advised:

- ❑ The gathering and evaluation of full orthodontic records.

Disposition:

- ❑ Undecided. Will call back.
- ❑ Patient not ready for orthodontic treatment at this time.
- ❑ Diagnostic records taken.
- ❑ Patient placed on recall.
- ❑ Record appointments scheduled.