Updated Ortho Packet

PATIENT REGISTRATION

Welcome to our office! We appreciate the confidence you place with us to provide orthodontic services. The information provided on this form is important to your dental health and treatment plan. If there have been any changes in your health, please inform us. If you have any questions, don't hesitate to ask.

1.First Name: | Middle Name: | Last Name: | Date of Birth:

Gender:
○ Male ○ Female

Mobile Phone No:

Responsible Party

2. Name: | Date of Birth:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Gender
○ Male ○ Female

Marital status:
○ Single ○ Married ○ Separated ○ Divorced ○ Widowed

Home Phone No:

Mobile Phone No:

Email:

INSURANCE INFORMATION

3.Primary Insurance Information

Do you have insurance?
○ Yes ○ No

Name of Policy Holder :

Policy Holder's ID# or SSN :

Policy Holder's Date of Birth *:

Employer:

Insurance Company:

Group #:

Insurance Provider Phone Number:

_____

4.Secondary Insurance Information

Do you have secondary insurance?

○ Yes ○ No

Name of Policy Holder :

_____

Policy Holder's ID# or SSN :

_____

Policy Holder's Date of Birth *:

_____

Employer:

_____

Insurance Company:

_____

Group #:

_____

REFERRAL INFORMATION

5.Whom may we thank for referring you?

- ☐ Patient
- ☐ Friend? If so who?
- ☐ Website
- ☐ Dental Office
- ☐ Relative
- ☐ School
- ☐ Social Media
- ☐ Work
- ☐ Online Search
- ☐ Other, explain?

_____

QUESTIONNAIRE

6.What are the concerns for which you are seeking treatment?

- ☐ Orthodontic?
- ☐ Pain, Sleep or Airway?
- ☐ Cosmetic, Resrorative or Other?

7.Speech Problems

- ☐ Difficult to understand child' speech
- ☐ Nasal Speech
- ☐ Lisp
- ☐ Any speech therapies?
- ☐ N/A

SLEEP QUESTIONNAIRE

8.How long does it take to fall asleep? hour/min *

_____

How many times do you hit snooze in the morning?

_____

How many naps do you take during the week? _____

What time do you usually go to bed during weekdays? _____

What time do you usually go to bed during weekends? _____

What time do you uusually wake up during weekdays? _____

What time do you usually wake up during weekends? _____

9.

	Yes	No
Do you snore at all?		
Does someone in your family snore?		
Have you had labored, difficult, loud breathing?		
Hyperactive?		
Mouth breathes during the day?		
Mouth breathes while sleeping?		
Headaches?		
Allergic symptoms, eczema, cradle cap, or frequent runny nose?		
Excessive sweating while asleep?		
Do you talk or scream in your sleep, have night terrors, or wake up confused?		
Do you sleepwalk?		
Do you kick in your sleep or wake with sheets in a mess?		
Poor ability in school?		
Falls asleep watching TV?		
Attention Deficit?		
Have leg pains, restless sleep, or sleep in unusual positions?		
Grinds teeth?		
Frequent throat infections?		
Feels sleepy and/or irritable during the day?		
Has a hard time listening and often interrupts?		
Fidgets with hands or does not sit quietly?		
Ever wets the bed?		
Any hearing problems?		
Wake up at night?		
Do you get sleep well, stay asleep well, and wake up feeling rested?		

10. Do you have vivid dreams?
○ Yes ○ No

Do you remember your dreams?
○ Yes ○ No

MEDICAL AND DENTAL HISTORY

11.General Dentist: _____

Present Health:
○ Good ○ Fair ○ Poor

12.List specific drugs or medications currently taken

	Medications:	Dosage:	Frequency:	Reason for Use:
1				
2				
3				

13.Has patient been under the care of a physician during the past 2 years other than for routine examinations?
○ Yes ○ No

Please Specify: _____

Has patient received treatment from an allergist or ear, nose and throat (ENT) specialist?
○ Yes ○ No

Has patient had tonsils and/or adenoids removed?
○ Yes ○ No

14.Please check if you have or have had any of the following

- ☐ AIDS
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Blood Diseases
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bone Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Dyslexia, ADD, ADHD
- ☐ Epilepsy
- ☐ Endocrine Problems
- ☐ Emotional Problems
- ☐ Hepatitis
- ☐ Heart Disease
- ☐ Hearing Disorder
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Sleep Disturbance
- ☐ Trauma to face, jaws or head
- ☐ Tuberculosis

15.Other Learning Disabilities (please specify if any)

_____

_____

_____

_____

16.Please check if you have any allergies to the following:

- ☐ Antibiotics
- ☐ Pain Pills
- ☐ Dairy Products
- ☐ Wheat, Cereal
- ☐ Food Dyes
- ☐ Latex
- ☐ Dust, Pollen
- ☐ Animals

Other: _____

17.Please indicate all descriptions that apply to the patient:

- ☐ Jaw has "locked" open or closed
- ☐ Difficulty chewing
- ☐ Pain and/or clicking in jaw joint?
- ☐ Permanent teeth erupt behind baby teeth
- ☐ Sucking Habits (thumb, finger, lip, etc.)
- ☐ Smokes
- ☐ Facial cosmetic surgery
- ☐ Teeth removed by dentist
- ☐ Unusual dental experience

18.Please describe any medical, dental or surgical problems not covered above:

_____

_____

_____

_____

19.Family members with similar orthodontic conditions.

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Grandparents

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

Responsible Party Signature:

_____ _____

Signature Date