Coastal Orthodontics

Welcome To Our Practice			**Today's Date**	
Patient Name			Birth Date	Age
Address	City		State	Zip
Primary Phone #	School			Grade
Is Patient Adopted Yes No				
Siblings in treatment? If yes, please list:				
Does patient play Sports or Instruments? If yes, list:				
Dentist	Phone #		Physician	Phone #

Information below applies to underage patients: To be completed by parent or guardian.

Mother's Name:			**Father's Name:**		
Home #	Cell #		Home #	Cell #	
Birth Date	SS #		Birth Date	SS #	
Is address same as patients? Yes No If not please list Address information below:			Is address same as patients? Yes No If not please list Address information below:		
Address			Address		
City	State	Zip	City	State	Zip
List spouse information if different than father's info:			List spouse information if different than mother's info:		
Name	Phone #		Name	Phone #	
Employer	Work #		Employer	Work #	

Legal Guardian/Temporary Care Taker Name:			
Relationship to Patient		Phone #	
Address	City	State	Zip
Information regarding custody situation:			

Dental Insurance: Orthodontic Coverage? Yes No			**Dental Insurance: Orthodontic Coverage? Yes No**		
Ins Name			Ins Name		
Subscriber Name			Subscriber Name		
Subscriber SS #	DOB		Subscriber SS #	DOB	
Claims Address			Claims Address		
City	State	Zip	City	State	Zip
Relationship to patient			Relationship to patient		
Employer			Employer		

Medical History	Please Circle	
Is patient currently taking medications? If yes, please list:	**Yes**	**No**
Any Allergies? If yes, please list:	**Yes**	**No**
Is patient in good health?	**Yes**	**No**
Have tonsils and/or adenoids been removed? If yes, at what age?	**Yes**	**No**
Are height and weight normal for age?	**Yes**	**No**
Frequent colds, sore throat or ear infections?	**Yes**	**No**
Any major illness? If yes, please describe:	**Yes**	**No**
Is patient currently under medical care?	**Yes**	**No**
Has patient been treated for any of the following? If yes, please circle: Diabetes Asthma Prolonged Bleeding Tonsillitis Heart Trouble Rheumatic Fever Arthritis Tuberculosis Epilepsy Nervous Disorders Brain Injury Endocrine Problems If condition not listed, please state: _____	**Yes**	**No**

Dental History		
Date of last dental cleaning: _____ Is work complete?	**Yes**	**No**
Have there ever been any injuries to face, mouth, or teeth?	**Yes**	**No**
Has patient ever sucked their thumb or fingers? Until what age: _____	**Yes**	**No**
Has patient ever had habits of chewing objects, fingernail biting, or tongue thrusting?	**Yes**	**No**
Has patient ever had any speech therapy?	**Yes**	**No**
Is patient a mouth breather while asleep or awake?	**Yes**	**No**
Has either parent or other children ever had orthodontic treatment?	**Yes**	**No**
What special concerns do you have or your dentist have?		
What do you hope to achieve through orthodontic treatment?		

Section For Female Patients Only		
Has 1st menstrual cycle begun? If yes, at what age? _____	**Yes**	**No**
Are you taking birth control?	**Yes**	**No**
IMPORTANT: ARE YOU PREGNANT AT THIS TIME? IF YES, HOW MANY WEEKS?_____	**Yes**	**No**
Are you nursing?	**Yes**	**No**

I have truthfully answered all the above questions and agree to inform this office of any changes in the above medical or dental history.

Parent / Guardian Signature Date

OFFICE USE ONLY	MEDICAL HISTORY UPDATE	MEDICAL HISTORY UPDATE
I verbally reviewed the medical and dental information above with the parent/guardian and patient named herein. Initials: _____ Date: _____ Doctor's Comments _____	Date: _____ Signature: _____ Comments: _____ _____ Date: _____ Signature: _____ Comments: _____ _____	Date: _____ Signature: _____ Comments: _____ _____ Date: _____ Signature: _____ Comments: _____ _____