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:
Phone #	Phone #
Email	Email
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 #

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

	Please Circle	
Medical History		
Is patient currently taking medications? If yes, please list:	**Yes**	**No**
Any Allergies? If yes, please list:	**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**
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**

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.

X

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: _____ _____