Howell Orthodontics, P.C.

PATIENT INFORMATION

Date: _____

Patient's Name: _____
Last First Middle

Address: _____
Street City State Zip

Email Address: _____

Phone Number: _____ Birthdate: _____ Age: _____ SS#: _____

General Dentist: _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Relationship to Patient Marital Status

Address: _____
Street City State Zip

Mailing address: _____
Street City State Zip

How long at this address? _____ Daytime Phone: _____ Evening Phone: _____

Previous Address (If less than 3 years): _____
Street City State Zip

SS#: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____
Last First Middle

Employer: _____ Occupation: _____ No. Years Employed: _____

SS#: _____ Birthdate: _____ Work Phone: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's SS or ID #: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

Do you have dual coverage? Yes No If yes:

Insured's Name: _____ Insured's SS#: _____

Insurance Co.: _____ Group #: _____ Telephone #: _____

Insurance Co. Address: _____
Street City State Zip

Insured's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address _____
Street City State Zip

Phone: _____

Initials (Parent/Guardian if minor): _____

DENTAL HISTORY

What are the main concerns you would like orthodontics to accomplish? _____

Has your child ever been evaluated or had orthodontic treatment before? Y N

Have there ever been any injuries to the face, mouth, teeth or chin? Y N

List any musical instruments played: _____

Have adenoids or tonsils been removed? Y N

Has your child been informed of any missing, extra, or impacted permanent teeth? Y N

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Y N

Does your child brush his/her teeth daily? Y N

Floss his/her teeth daily? Y N

Child's Physician? _____

Phone #: _____ Date of last visit: _____

Is your child currently under the care of a physician? Y N

Please describe your child's current physical health:

Good Fair Poor

Does your child have any speech problems: _____

Please list all drugs your child is currently taking: _____

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Abnormal bleeding	Y	N	Diabetes	Y	N
Allergies to any drugs	Y	N	Handicaps/Disabilities	Y	N
Allergic to latex/metal	Y	N	Hearing impairment	Y	N
Allergic to plastic	Y	N	Heart murmur	Y	N
Any hospital stays	Y	N	Hemophilia	Y	N
Any operations	Y	N	Hepatitis	Y	N
Asthma	Y	N	HIV+/AIDS	Y	N
Cancer	Y	N	Kidney/Liver defects	Y	N
Chicken Pox	Y	N	Rheumatic/Scarlet fever	Y	N
Congenital heart defects	Y	N	Tuberculosis	Y	N
Convulsions/Epilepsy	Y	N			

Please discuss any medical problems that your child has had:

HABITS

Does/did your child have any of the following habits?:

Clenching/Grinding teeth	Y	N	Nursing bottle habits	Y	N
Lip sucking/biting	Y	N	Thumb/Finger sucking	Y	N
Mouth breather	Y	N	Tongue thrust	Y	N
Nail biting	Y	N			

Please discuss any other concerns: _____

Signature (Parent/Guardian if minor): _____ Date: _____

Updates (dates/initial): _____

Reviewed: _____ Date: _____