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

Residence: _____
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: _____

MEDICAL HISTORY

Do you have a personal physician? ☐ Y ☐ N

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician: ☐ Y ☐ N

If yes, please explain: _____

Are you taking any prescription/over-the-counter drugs? ☐ Y ☐ N

If yes, please list each one: _____

Have you ever had any of the following diseases or medical problems?

Anemia	☐Y ☐N	Heart Surgery/Pacemaker	Y☐ N☐
Arthritis	☐Y ☐N	Hemophilia/Abnormal	Y☐ N☐
Artificial Bones/Joints	☐Y ☐N	Bleeding	Y☐ N☐
Artificial Valves	☐Y ☐N	Hepatitis	Y☐ N☐
Asthma	☐Y ☐N	High/Low Blood Pressure	Y☐ N☐
Blood Transfusion	☐Y ☐N	HIV+/AIDS	Y☐ N☐
Cancer/Chemotherapy	☐Y ☐N	Hospitalized (any reason)	Y☐ N☐
Congenital Heart Defect	☐Y ☐N	Kidney Problems	Y☐ N☐
Diabetes	☐Y ☐N	Mitral Valve Prolapse	Y☐ N☐
Difficulty Breathing	☐Y ☐N	Psychiatric Treatment	Y☐ N☐
Drug/Alcohol Abuse	☐Y ☐N	Radiation Therapy	Y☐ N☐
Emphysema	☐Y ☐N	Rheumatic/Scarlet Fever	Y☐ N☐
Glaucoma	☐Y ☐N	Shingles	Y☐ N☐
Epilepsy/Seizures	☐Y ☐N	Sinus Problems	Y☐ N☐
Fainting Spells	☐Y ☐N	Tuberculosis (TB)	Y☐ N☐
Fever Blisters/Cold Sores	Y☐ N☐	Ulcer/Colitis	Y☐ N☐
Heart Attack/Stroke	☐Y ☐N	Venereal Disease (STD)	Y☐ N☐
Heart Murmur	☐Y ☐N		

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?:

Aspirin	☐Y ☐N	Latex	☐Y ☐N
Any metals or plastics	☐Y ☐N	Penicillin	☐Y ☐N
Codeine	☐Y ☐N	Tetracycline	☐Y ☐N
Dental Anesthetics	☐Y ☐N	Other	☐Y ☐N
Erythromycin	☐Y ☐N		

Please list any other drugs/materials you are allergic to: _____

For Women:

Are you taking birth control pills? Y☐ N☐

Are you pregnant? Y☐ N☐

If yes, Week #: _____

Are you nursing? Y☐ N☐

DENTAL HISTORY

Do you currently have a general dentist? Y☐ N☐

How long has it been since your last dental check-up? _____ (Months)

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

Have you ever been evaluated for orthodontic treatment? Y☐ N☐

Have you ever had a difficult problem associated with any previous dental work? Y☐ N☐

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Y☐ N☐

Your current dental health is: ☐Good ☐Fair ☐Poor

Do you like your smile? Y☐ N☐

Do your gums ever bleed? Y☐ N☐

Have you ever had an injury to your: Mouth? Teeth? Chin?☐

Do you have any speech problems? Y☐ N☐

If yes, please explain: _____

Do you generally breathe through your mouth? Awake? Y☐ N☐

Asleep? Y☐ N☐

Do you have any missing, extra, or impacted permanent teeth? Y☐ N☐

Please discuss any other concerns: _____

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

Updates (dates/initial): _____

Reviewed: _____ Date: _____