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: _____