BLUE-SKY ORTHODONTICS

Members American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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Patient Name _____ Nickname_____ Sex_____

Birthdate_____ Age_____

Address_____

City_____ State_____ Zip_____ Home Phone_____

Dentist_____ Physician_____

How did you hear about our office?_____

What questions would you like answered today?_____

COMPLETE FOR A CHILD/TEEN PATIENT:

School_____ Grade_____ Musical Instrument_____

Sports _____ Hobbies/Interests _____

Father's Name_____ Cell Phone_____ Work Phone_____

Address _____ City_____ State_____ Zip_____

Employer_____ E-mail _____

Mother's Name _____ Cell Phone_____ Work Phone_____

Address (if not the same)_____ City_____ State_____ Zip_____

Employer_____ E-mail _____

COMPLETE FOR AN ADULT PATIENT:

Your Employer_____ E-mail _____ Work Phone_____

Spouse's Name_____ Employer_____ Work Phone_____

DENTAL INSURANCE INFORMATION: (Please use information from your insurance card to complete this section)

Primary

Ins. Co._____

Phone#_____

Policy Holder Name_____

SS#_____

Group#_____

Employer_____

Secondary

Ins. Co._____

Phone#_____

Policy Holder Name_____

SS#_____

Group#_____

Employer_____

Person(s) responsible for payment & relationship to patient:_____

OVER FOR MORE INFORMATION

MEDICAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorders
- ☐ Blood Transfusions
- ☐ Bruise Easily
- ☐ Cerebral Palsy
- ☐ Congenital Heart Disease
- ☐ Diabetes
- ☐ Emotional Problems
- ☐ Endocrine Disorders
- ☐ Epilepsy (Convulsions)
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Heart Murmur/Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disorders
- ☐ Latex Sensitivity
- ☐ Liver Disease
- ☐ Metal Sensitivity
- ☐ Mitral Valve Prolapse
- ☐ Neurologic Disorders
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Thyroid Problems
- ☐ Tonsil or Adenoid Removal
- ☐ Tuberculosis

STATE ANY REASONS WHY THE PATIENT IS CURRENTLY UNDER THE CARE OF A PHYSICIAN _____

_____

LIST ANY DRUG ALLERGIES OR SENSITIVITIES _____

LIST ANY MEDICATIONS THAT THE PATIENT IS CURRENTLY TAKING _____

_____

HAS THE PATIENT BEEN ADVISED THAT ANTIBIOTICS SHOULD BE TAKEN PRIOR TO DENTAL PROCEDURES? (YES OR NO) _____

LIST ANY OTHER SERIOUS ILLNESSES, OPERATIONS OR DISEASES NOT LISTED ABOVE _____

_____

DEVELOPMENTAL HISTORY FOR CHILD/TEEN

PATIENT'S HEIGHT _____ PATIENT'S WEIGHT _____

GIRLS ONLY: HAS PATIENT STARTED MONTHLY CYCLE? _____ IF YES, AGE OF ONSET? _____

IS THE PATIENT PREGNANT? _____

DENTAL HISTORY

DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK WHEN YES)

- ☐ Bleeding Gums
- ☐ Chronic Facial Pain
- ☐ Clenching or Grinding of Teeth
- ☐ Difficulty Chewing or Swallowing
- ☐ Dizziness
- ☐ Frequent Canker Sores
- ☐ Injuries to Face or Teeth
- ☐ Jaw Joint Pain
- ☐ Jaw Joints Pop or Click
- ☐ Jaw Locking Open or Closed
- ☐ Limitation in Mouth Opening
- ☐ Missing or Extra Permanent Teeth
- ☐ Mouth Breathing
- ☐ Muscle Tenderness in Jaw or Neck
- ☐ Nail Biting
- ☐ Periodontal Surgery
- ☐ Permanent Teeth Removed
- ☐ Speech Problems
- ☐ Sucks Thumb, Finger or Lip
- ☐ Teeth Sensitivity - Hot/Cold
- ☐ Tongue Thrust

DATE OF LAST DENTAL CLEANING AND EXAM _____

LIST ANY DENTAL PROBLEMS WE SHOULD KNOW ABOUT _____

HAS THE PATIENT RECEIVED AN EVALUATION OR TREATMENT IN ANOTHER ORTHODONTIC OFFICE? (YES OR NO) _____

IF YES, BY WHOM? _____

LIST THE PATIENT'S CHIEF CONCERNS AND WHAT THEY WOULD LIKE THIS ORTHODONTIC TREATMENT TO ACCOMPLISH

_____

AUTHORIZATION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical or dental status. I authorize release of any information to insurance carriers and to other health care providers involved in my child's care. I authorize Dr. Cassaidy, Dr. Poss and the dental staff to perform any necessary dental services that are needed during diagnosis and treatment.

SIGNATURE (IF MINOR, PARENT'S SIGNATURE) _____ **DATE** _____

FOR OFFICE USE
UPDATES (DATE AND INITIAL)