Eggemeyer & Graham Orthodontics, Ltd.

Orthodontic Patient Information

Patient Name: _____ **Birthdate:** _____ **Age:** _____
Address: _____ **Home Phone:** _____ **Gender:** _____
City, St, Zip: _____ **Work Phone:** _____
School / Employer: _____ _____

Person(s) Responsible for financial matters **Same as above:** ☐

Name: _____ **Home Phone:** _____
Address: _____ **Work Phone:** _____
City, St, Zip: _____ **Mobile Phone:**
Place of Employment: _____ **Email:** _____
Date of Birth: _____ **Relation to patient:** _____

Name: _____ **Home Phone:** _____
Address: _____ **Work Phone:** _____
City, St, Zip: _____ **Mobile Phone:** _____
Place of Employment: _____ **Email:** _____
Date of Birth: _____ **Relation to patient:** _____

Is the patient covered by insurance for orthodontic treatment? ☐**No** ☐**Yes**

Dentist Name: _____ **Physician Name:** _____
Address: _____ **Address:** _____
_____ _____
City, St, Zip: _____ **City, St, Zip:** _____
Phone: _____ **Phone:** _____
Referred By: _____

Family History

Parent/Guardian #1 Name: _____ **Occupation:** _____
Parent/Guardian #2 Name: _____ **Occupation:** _____
Siblings (name and age): _____
Marital Status of parents: _____ **Patient Living with:** _____

Medical History Has the patient ever had: (circle all that apply)

Allergy	Bleeding	Emotional Problems	Hepatitis	Oral Ulcer
Anemia	Cold Sores	Epilepsy/Seizures	HIV+	Previous Surgery
Arthritis	Diabetes	Heart Condition	Kidney Disease	Rheumatic Fever
Asthma	Endocrine Problem	Head or Face Injury	Lung Disease	Thyroid Problems

Other: _____

_____

Has the patient been under the care of a physician during the past two year, other than for routine examination?
☐**No** ☐**Yes, condition:** _____

Birth Defects: _____

Has the patient reached puberty? ☐**Yes** ☐**No**

Is premedication required for dental procedures? (Certain heart conditions) ☐**Yes** ☐**No**

Present medications, homeopathics or vitamins: _____

Respiratory History

Does the patient:

1. **Have allergies to:** Latex _____ Seasonal grasses _____ Any Metal _____
   Drugs _____ Food _____ Other _____
2. **Breath through mouth?** ☐No ☐Sometimes ☐Usually
3. **Snore when sleeping?** ☐No ☐Sometimes ☐Usually
4. **Have frequent colds?** ☐No ☐Yes
5. **Have frequent "stuffy nose"?** ☐No ☐Yes
6. **Have frequent sore throat or tonsillitis?** ☐No ☐Yes
7. **Have chewing or swallowing difficulty?** ☐No ☐Yes

Has the patient received medical treatment from allergist or Ear/Nose/Throat specialist?

☐No ☐Yes: When_____ By Whom_____

Adenoids removed_____ Tonsils removed_____ Nasal Surgery_____

Dental and Temporomandibular Joint History

Has the patient had any unusual dental experiences? _____

_____

Date of last dental checkup: _____ **Were the patient's teeth cleaned?** ☐Yes ☐No

Has the patient ever been treated for T.M.J ("Jaw Joint") problem? _____

Does the patient have:

1. **Difficulty in mouth opening?** ☐No ☐Yes
2. **Pain or clicking in jaw joint?** ☐No ☐Yes
3. **Pain on chewing, yawning or wide opening?** ☐No ☐Yes
4. **Pain in or about the ears or cheeks?** ☐No ☐Yes
5. **A bite that feels uncomfortable or unusual?** ☐No ☐Yes
6. **A jaw that locks, gets stuck or goes out?** ☐No ☐Yes
7. **Noises in or from the jaw joints?** ☐No ☐Yes

The following habits are of interest. List information as it pertains to the patient:

1. **Thumb/Finger/Lip sucking** ☐No ☐Yes **until _____ (age)**
2. **Grinding or Clenching of teeth** ☐No ☐Yes
3. **Tongue thrusting or other functional problems** ☐No ☐Yes

Has the patient had previous orthodontic consultation? ☐No ☐Yes

Treatment? ☐No ☐Yes: Date _____ Dr.: _____

Why did patient seek this consultation? _____

What is the primary problem? _____

_____

What is expected from orthodontic treatment? _____

Signature of person completing this form: _____ **Relationship to patient:** _____

Today's Date: _____ **Doctor reviewed medical history:** _____

Date updated medical history: _____ **Dr:** _____

Date updated medical history: _____ **Dr:** _____

Date updated medical history: _____ **Dr:** _____

Date updated medical history: _____ **Dr:** _____