Eggemeyer & Graham Orthodontics, Ltd.

Orthodontic Patient Information

Patient Name:_____ Birthdate: _____ Age: _____ Sex:_____
Address: _____ Home Phone:_____
City, St. Zip:_____Work Phone:_____
Email:_____Cell Phone:_____
School:_____

Person(s) responsible for financial matters: Same as above ☐
Name:_____Home Phone:_____
Address:_____Work Phone:_____
City, St, Zip:_____Cell Phone:_____
Employment:_____Email:_____
Relation to Patient:_____

Name:_____ Home Phone:_____
Address:_____Work Phone:_____
City, St, Zip:_____ Cell Phone:_____
Employment:_____ Email:_____
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 Problems	Head or Face Injury	Lung Disease	Thyroid Problems

Other:_____
_____

Has the patient been under the care of physician the past two years, other than for routine exam?
No ☐ Yes, condition:_____
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: Seasonal grasses_____ Food_____
Drugs_____Latex_____Other_____
2. Breathe through mouth? Seldom Sometimes Usually
3. Snore when sleeping? No Yes
4. Have frequent colds? No Yes
5. Have frequent "stuffy nose"? No Yes
6. Have frequent sore throat? 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 TMJ (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 with chewing/yawning/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 joint? No Yes

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

1. Thumb/finger/lip sucking No Yes
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/concern?_____
_____
What is expected from orthodontic treatment?_____
Signature of individual completing this form:_____Date:_____
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.:_____