

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: _____