KELLEY ORTHODONTICS

PATIENT INFORMATION

Date _____

First name _____ M.I. ____ Last name _____ Nickname _____

SS #_____ Sex _____ Date of birth _____ Age _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email _____

School (if student) _____ Grade _____ Hobbies _____

Occupation _____ Employer_____

Whom may we thank for recommending us? _____ Dentist _____

Related patients that are or have been under our care _____

Names and ages of other children _____

PARENT INFORMATION (Please complete if patient is a minor)

Father's name _____

SS # _____ DOB _____

Address _____

City _____ ST _____ Zip _____

H Phone _____ Wk Phone _____

C Phone _____ Fax _____

Email _____

Occupation_____

Employer _____

Address _____

City _____ ST _____ Zip _____

Mother's name _____

SS # _____ DOB _____

Address _____

City _____ ST _____ Zip _____

H Phone _____ Wk Phone _____

C Phone _____ Fax _____

Email _____

Occupation_____

Employer _____

Address _____

City _____ ST _____ Zip _____

Divorced? ☐ Yes ☐ No If yes, who is the custodial parent? _____

May patient information be released to the non-custodial parent? ☐ Yes ☐ No

Who is the responsible party? ☐ Father ☐ Mother ☐ Other (If other, please fill out the contact information below)

Name _____ Relationship to patient _____ SS # _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Work phone _____

Email _____

INSURANCE INFORMATION

Do you have insurance that covers orthodontic treatment? ☐ Yes ☐ No

Policy holder _____ ID/Group number _____

Name of insurance company _____ Phone number _____

MEDICAL HISTORY

Is the patient in good general health? ☐ Yes ☐ No

Has there been a change in general health within the last year? ☐ Yes ☐ No

Is the patient currently under the care of a physician? ☐ Yes ☐ No

If yes, what is being treated? _____

Physician's name _____

Has patient been hospitalized in the last five years? ☐ Yes ☐ No

If yes, reason for hospitalization? _____

Please check if the patient currently has or had a history of any of the following conditions:

☐ Bone disorders	☐ Kidney or liver involvement	☐ Tonsils removed
☐ Heart trouble	☐ Joint prosthesis	☐ Adenoids removed
☐ Mitral valve prolapse	☐ Tuberculosis	☐ Earaches
☐ Rheumatic trouble	☐ Anemia	☐ Arthritis
☐ Thyroid problems	☐ Epilepsy	☐ Sexually transmitted disease
☐ Diabetes	☐ Prolonged bleeding	☐ AIDS or HIV
☐ Emotional problems	☐ Faintness or dizziness	☐ Females - are you pregnant?
☐ Brain injury	☐ Adopted	☐ Females - has menstruation begun?

Has the patient ever taken bisphosphonates or other bone medications? ☐ Yes ☐ No

List any other serious illness _____

List any allergies_____

List all drugs and medications currently being taken _____

Do you have any disease, condition, or problem not listed above that you think we should know about? If so, please explain:

_____

_____

DENTAL HISTORY

Please check if the patient currently has or had a history of any of the following dental conditions:

☐ Injuries to the face, mouth, or teeth	☐ Bleeding of gums/bad taste in mouth	☐ History of TMJ disorder
☐ Thumb, finger, or lip sucking habit	☐ Teeth sensitive to hot/cold	☐ Pain in the jaw joint
☐ More than average amount of decay	☐ Periodontal problems	☐ Pain in the muscles of the face
☐ Any missing permanent teeth	☐ Frequent ulcers/canker sores	☐ Clicking/popping/locking of jaw joint
☐ Extra permanent teeth	☐ Abnormal swallowing/tongue thrust	☐ Been treated for "TMJ"
☐ Teeth removed by extraction	☐ Mouth breathing habit	☐ Bite feel uncomfortable
☐ Difficulty in swallowing or chewing	☐ Negative dental experience	☐ Grinding/clenching of teeth

Has an orthodontist been consulted previously? ☐ Yes ☐ No

Reason _____

What would you like treatment to accomplish? _____

Comments _____

I certify that I have read and understand the above. I acknowledge that I have completed the form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I may have made. If there are any future changes to this history record, I will inform the practice.

Signature: _____ Date: _____