CASCADE BRACES

WELCOME TO OUR OFFICE

New Patient Information Form

Patient's name_____ Sex _____Date_____

Address_____ City_____ State_____ Zip_____

Phone_____ Date of Birth_____ Age_____ Parent Name_____

School_____ Grade_____ Dentist_____

Who Referred You?_____ Email_____

Responsible Party Information

Name_____ Marital status_____

Address_____

Home Phone_____ Cell Phone_____ Email _____

Relationship to Patient_____ Date of Birth_____ Social Security_____

Orthodontic/Dental Insurance information

Primary Subscribers Name_____Birthdate_____

Insurance Company Name_____ ID#_____

Insurance Company Phone_____ Group #_____

Insurance Company Address_____ Employer_____

Secondary Subscribers Name_____Birthdate_____

Insurance Company Name_____ ID#_____

Insurance Company Phone_____ Group #_____

Insurance Company Address_____Employer_____

Emergency Contact Information

Name_____ Phone Number _____Relationship to Patient_____

For the following questions mark yes, no, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Now or in the past, have you had (Circle One)

oyes ono odk/u Birth defects or hereditary problems?
oyes ono odk/u Bone fractures, any major accidents?
oyes ono odk/u Rheumatoid or arthritic conditions?
oyes ono odk/u Endocrine or thyroid problems?
oyes ono odk/u Kidney problems?
oyes ono odk/u Diabetes? If yes, Type I or Type II?
oyes ono odk/u Cancer, tumor, radiation treatment or chemotherapy?
oyes ono odk/u Stomach ulcer or hyperacidity?
oyes ono odk/u Polio, mononucleosis, tuberculosis, or pneumonia?
oyes ono odk/u Problem of the immune system ?
oyes ono odk/u AIDS or HIV positive?
oyes ono odk/u Hepatitis, jaundice or liver problem?
oyes ono odk/u Fainting spells, seizures, epilepsy or neurological problem?
oyes ono odk/u Mental health disturbance or behavioral problem?
oyes ono odk/u Vision, hearing, tasting or speech difficulties?
oyes ono odk/u Loss of weight recently, poor appetite?
oyes ono odk/u History of eating disorder (anorexia, bulimia)?
oyes ono odk/u Excessive bleeding or bruising tendency, anemia?
oyes ono odk/u High or low blood pressure?
oyes ono odk/u Tires easily?
oyes ono odk/u Chest pain, shortness of breath or swelling ankles?
oyes ono odk/u Skin disorder?
oyes ono odk/u Do you eat a well-balanced diet?
oyes ono odk/u Frequent headaches, colds or sore throats?
oyes ono odk/u Eye, ear, nose or throat condition?
oyes ono odk/u Tonsil or adenoid conditions?
oyes ono odk/u Hay fever, asthma, sinus trouble?
oyes ono odk/u Osteoporosis?
oyes ono odk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

Allergies or reactions to any of the following?

oyes ono odk/u Latex (gloves, balloons)?
oyes ono odk/u Metals (jewelry, clothing snaps)?
oyes ono odk/u Local anesthetics, such as Lidocaine?
oyes ono odk/u Acrylic
oyes ono odk/u Medications (please specify) _____
oyes ono odk/u Foods (please specify) _____
oyes ono odk/u Other substances (specify) _____
oyes ono odk/u Are you taking medication, nutrient supplements, herbal medications or non-prescription medicine? If yes, please name them:

Medication _____ Taken For: _____
Medication _____ Taken For: _____

oyes ono odk/u Do you currently have or have had substance abuse problem?
oyes ono odk/u Do you smoke or chew tobacco?
oyes ono odk/u Operations? Describe: _____

oyes ono odk/u Hospitalized? For: _____
oyes ono odk/u Being treated by another health care professional? If yes, for? _____
oyes ono odk/u Other physical problems or symptoms?
Describe: _____
Are there any other medical conditions (including family medical conditions) that we should be aware of? _____
_____

Now or in the past, have you had (Circle One)

oyes ono odk/u Permanent or "extra" (supernumerary teeth removed?
oyes ono odk/u Supernumerary (extra) or congenitally missing teeth?
oyes ono odk/u Chipped or otherwise injured primary (baby) or permanent teeth?
oyes ono odk/u Teeth sensitive to hot or cold; teeth throb or ache?
oyes ono odk/u Jaw fractures, cysts or mouth infections?
oyes ono odk/u "Dead teeth" or root canals treated?
oyes ono odk/u Bleeding gums, bad taste or mouth order
oyes ono odk/u Periodontal "gum" problems?
oyes ono odk/u Food impaction between teeth?
oyes ono odk/u "Gum Boils", frequent canker sores or cold sores?
oyes ono odk/u Thumb, finger or sucking habit? Until what age?
oyes ono odk/u Abnormal swallowing habit (tongue thrusting)?
oyes ono odk/u History of speech problems?
oyes ono odk/u Mouth breathing habit, snoring or difficulty breathing?
oyes ono odk/u Tooth grinding, jaw clenching clicking or locking?
oyes ono odk/u Any pain in jaw or ringing in the ears?
oyes ono odk/u Any pain or soreness in the muscles of or around the face or around the ears?
oyes ono odk/u Difficulty encountered in chewing or jaw opening?
oyes ono odk/u Have you ever been treated for "TMD or "TMJ"?
oyes ono odk/u Aware of loose, broken or missing restorations "fillings"?
oyes ono odk/u Any teeth irritating cheek, lip, tongue or palate?
oyes ono odk/u Concerned about spaced, crooked or protruding teeth?
oyes ono odk/u Aware or concerned about under or over developed jaw?
oyes ono odk/u Any relative with similar tooth or jaw relationships?
oyes ono odk/u Any wisdom tooth problems?
oyes ono odk/u Had periodontal (gum) treatment?
oyes ono odk/u Had any serious trouble associated with any previous dental treatment?
oyes ono odk/u Ever had a prior orthodontic examination or treatment?
oyes ono odk/u Been under another dentist's care?
oyes ono odk/u Been under another dental specialist's care?
oyes ono odk/u Would you object to wearing orthodontic appliances (braces) should they be prescribed?

Women Only

oyes ono odk/u Are you pregnant?
oyes ono odk/u Are you anticipating becoming pregnant?

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I understand that where appropriate, credit bureau reports may be obtained.
I understand and agree that I am responsible for payment. I certify that this information is true and correct to the best of my knowledge.

Signature_____Date_____