PORTLAND BRACES

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Today's Date ______________________

Patient's First Name___________________ Middle Initial ______ Last Name_____________________ Date of Birth_________ Age_____

Patient's Dentist _______________________________ Referred By ______________________ School & Grade ____________________

Who is accompanying the patient today? _______________________________Relationship to patient? ______________________________

Who is financially responsible for this account? ____ Adopted? _____________

Reason for Orthodontic Consultation____

Patient's Guardian

First Name____

Last Name____

Date of Birth________________________ Sex_____________

Address____

City/State/Zip_______________________________________

Home Phone____

Cell Phone____

Occupation____

Employer____

Insurance Company___________________________________

ID Number____

Group Number______________________________________

Social Security Number_______________________________

Insurance Phone Number______________________________

Email ____

Would you like to receive email reminders? Yes ___ No ___

Would you like to receive text message reminders? Yes___ No ___

If yes; who is your cell phone carrier? _____________________

Other adults we should know about such as stepparents?

First Name____

Last Name____

Relationship to patient__________________________________

Home Phone____

Cell Phone____

Patient's Guardian

First Name____

Last Name____

Date of Birth__________________________ Sex___________

Address____

City/State/Zip_______________________________________

Home Phone____

Cell Phone____

Occupation____

Employer____

Insurance Company___________________________________

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Other adults we should know about such as stepparents?

First Name____

Last Name____

Relationship to patient__________________________________

Home Phone____

Cell Phone____

Medical History

Physician's name____City_____________________________________

Is the patient taking any medication or drugs?____

Does the patient have a history of major illness or hospital stay?____

Please check the following that the patient has been diagnosed with:

- ☐ Allergies (seasonal)
- ☐ Allergies (metal)
- ☐ Allergies (latex)
- ☐ Allergies (medication)
- ☐ Asthma
- ☐ Congenital Defects
- ☐ Behavorial/Learning problems
- ☐ Diabetes (Type:_______________________)
- ☐ Epilepsy
- ☐ Headaches (Frequency________________________)
- ☐ Heart Murmur
- ☐ HIV/Aids
- ☐ Bisphosphonates (ex. Fosamax, Boniva, Actonel, Didronel)
- ☐ Rheumatic Fever
- ☐ Psychiatric Illness (ex. depression, bipolar, anxiety)
- ☐ Tuberculosis

Please describe other medical concerns: ____

____

Special needs: ____

Have tonsils and adenoids been removed? _____________________________If yes, what age? ________________

Has the patient ever sucked a thumb or fingers? ___________________________ If yes, until what age? ______________

Has the patient or other family members had any previous orthodontic treatment? ________________________________

Has the patient been informed of any missing or extra permanent teeth? _______________________________________

Does the patient have any jaw pain or noise in the jaw joint? ____

Does the patient play a musical instrument (mouth only)? ____________________ If yes, hours per day_______________

Girls only: Have menstrual periods started? ______________ If yes, at what age? __________________________

Boys only: Voice change? ______________ Facial hair? _________________ If yes, at what age? ________________

Is there a possibility of pregnancy? _______________________________ Expected Delivery Date? _______________

Signature ____ Today's Date ______________________