POWER ORTHODONTICS

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PATIENT INFORMATION & HEALTH HISTORY

INFORMATION

Patient's Name_____ Birth Date_____ Patient is ☐ Male ☐ Female
Home Address_____ City_____ St_____ Zip_____
Home Phone_____ Cell Phone_____ Patients Dentist_____
Email Address_____ **Whom may we thank for your referral?**_____
Cell Phone Carrier_____ **Preferred Contact** Text Message or Email

RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____
Home Address_____ Birth Date_____
Home Phone:_____ Work Phone _____ Cell Phone _____
Your Employer_____ Your Occupation_____
Social Security No._____ Email Address:_____
Spouse's Name_____ Spouse's Address_____
Spouse's Employer_____ Social Security No._____ Birth Date_____
Spouse's Occupation_____ Work Phone_____
Primary Insurance & Subscriber_____ Secondary Ins. & Subscriber_____

HEALTH HISTORY

MEDICAL HISTORY - Please check if patient has, or has had…

- ☐ Joint Swelling or Arthritis
- ☐ Diabetes
- ☐ Bone Disorders
- ☐ Heart Trouble/Heart Murmur
- ☐ Rheumatic Fever
- ☐ Hepatitis or Liver Problems
- ☐ Emotional Problems/ADDH/Autism Meds:_____
- ☐ Tuberculosis (TB)
- ☐ AIDS or HIV
- ☐ Epilepsy
- ☐ Prolonged Bleeding
- ☐ Endocrine Problems
- ☐ Artificial Joints
- ☐ Girls: Started menstruation? ☐ Yes ☐ No First Cycle_____
- ☐ Boys: Voice changed? ☐ Yes ☐ No
- ☐ Tonsils Removed (If so when?) _____
- ☐ Asthma (if so, what medication(s)? _____
- ☐ Are you pregnant? How far along? _____
- ☐ Allergies ☐ Drugs: _____
  ☐ Seasonal Meds:_____
  ☐ Latex ☐ Nickel ☐ Nuts

DENTAL HISTORY – Please check if patient has, or has had…

- ☐ Any injuries to ☐ face, ☐ mouth, ☐ teeth?
- ☐ Thumb, finger or lip sucking habit (s) Discontinued at age ____
- ☐ Mouth breathing when ☐ awake, ☐ asleep?
- ☐ Any know missing permanent teeth?
- ☐ Any know extra permanent teeth?
- ☐ Any teeth removed by extraction? If so, when_____
- ☐ A tongue thrust problem? ☐ Speech problems?
- ☐ Any clenching or grinding of teeth? ☐ Day ☐ Night ☐ Both
- ☐ Any pain, popping, or locking on opening or closing jaw?
- ☐ Frequent headaches? If so, number per week____ AM or PM
- ☐ Any muscle tenderness or stiffness in the ☐ Jaw ☐ Neck
- ☐ Any ☐ ringing sounds in the ear or ☐ spells of dizziness?
- ☐ Any previous treatment for TMJ or jaw point problems?
- ☐ Any previous orthodontic evaluation or treatment?

Are you under doctor's care now? ☐ Yes ☐ No
For what? _____
Name of Physician:_____
☐ Allergies-Other:_____

PLEASE LIST YOUR **CHIEF CONCERN(S)** AND WHAT YOU WOULD LIKE TREATMENT TO ACCOMPLISH:

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Rebeca Power to perform a complete orthodontic evaluation.

Signature of Person Completing Form:_____ Date:_____
Doctors Signature:_____ Date:_____