Carlsbad Village
ORTHODONTICS

PATIENT LAST NAME _____ First Name_____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female Email_____

Address _____ City _____ Zip _____

Home Phone _____ Mobile Phone _____ Work Phone_____

Occupation (or) School / Grade _____

How did you hear about us?_____

Patient's Dentist _____ Phone No _____

Address _____

Patient's Physician _____ Phone No _____

Emergency Contact _____ Phone No _____

Marital Status of Parents or Self: S M D W

FATHER'S NAME (IF MINOR) _____ Social Security No. _____

Employer _____ Occupation _____

Employer's Address _____ Employer's Phone _____

MOTHER'S NAME (IF MINOR)_____ Social Security No. _____

Employer _____ Occupation _____

Employer's Address _____ Employer's Phone _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____Social Security Number _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Mobile Phone _____ Work Phone _____

Email _____Employer _____

Insurance Co _____Group No _____ Insurance Co Phone _____

Insurance Co Address _____City_____State_____Zip_____

PERSONAL INTERESTS

Does the patient play any sports? (Please list) _____

Does the patient play any musical instruments? _____

Other hobbies or interests? _____Pets?_____

_____

Printed Patient or Parent Name (if minor)

_____ _____

Signature of Patient or Parent (if minor) Date

Patient Name _____

Health History

Your estimate of patient's health: ☐ Good ☐ Fair ☐ Poor

Have there been any changes in health in the last year? ☐ Yes ☐ No Explain:_____

Does the patient have any history of major illness? ☐ Yes ☐ No Explain: _____

Have tonsils/adenoids been removed? ☐ Yes ☐ No Date _____

Females: Have you started menstruation? ☐ Yes ☐ No Date _____

Are you pregnant? ☐ Yes ☐ No Months into pregnancy: _____ Due Date _____

Check any of the following for which patient has a history of:

	Y	N		Y	N		Y	N
Diabetes	☐	☐	Herpes	☐	☐	Prosthetic valve/limb	☐	☐
Epilepsy	☐	☐	Chicken Pox	☐	☐	Kidney Involvement	☐	☐
Liver Disease	☐	☐	Heart Trouble	☐	☐	Frequent Headaches	☐	☐
Heart Murmur	☐	☐	Allergies/Hay Fever	☐	☐	Hives or skin rash	☐	☐
High Blood Pressure	☐	☐	Tuberculosis	☐	☐	Fainting or Dizziness	☐	☐
AIDS	☐	☐	Bone Disorder	☐	☐	Prolonged Bleeding	☐	☐
Asthma	☐	☐	Mental Therapy	☐	☐	Sinus Troubles	☐	☐
Jaundice	☐	☐	Mental Illness	☐	☐	Endocrine Problem	☐	☐
Arthritis	☐	☐	Rheumatic Fever	☐	☐			

Are you allergic to or have adverse reactions to:

	Y	N		Y	N
Penicillin	☐	☐	Codeine	☐	☐
Erythromycin	☐	☐	Motrin (Ibuprofin)	☐	☐
Tetracycline	☐	☐	Aspirin	☐	☐
Local anesthetics	☐	☐	Valium (Diazapam)	☐	☐
Latex	☐	☐	Other	☐	☐

Please list any medications and the dosage you are taking:

_____

_____

_____

_____

_____

Please list any other medical condition not mentioned above: _____

Dental History

	Y	N	
Any history of injuries to face, mouth, or teeth?	☐	☐	
Has patient ever sucked thumb, finger, or lip, pen/pencil, etc?	☐	☐	If so, until what age? _____
Does patient have any speech problems?	☐	☐	
Is nasal breathing difficult for patient?	☐	☐	
Has patient been informed of any missing or extra permanent teeth?	☐	☐	
Does patient have any difficulty chewing food?	☐	☐	
Does patient have bleeding gums?	☐	☐	
Has patient ever had mouth or lip sores which were slow to heal?	☐	☐	
Has patient ever had Jaw pain/trauma/clicking/popping or other TMJ problems?	☐	☐	
Is patient dissatisfied with or sensitive about their dental appearance?	☐	☐	
Has patient had previous orthodontic treatment or a consult?	☐	☐	
Has either parent had orthodontic treatment?	☐	☐	Were extractions necessary?_____

What are your primary concerns that brought you in for an orthodontic evaluation? _____

Date of last general dental visit _____ What was done? _____

I certify the above to be true to the best of my knowledge. I authorize the doctor to examine me (or my child) and obtain the necessary diagnostic information.

_____ _____

Patient/ or Parent Signature Date Doctor Signature Date

UPDATES TO HEALTH HISTORY: