A B C

Date _____

PATIENT INFORMATION AND HEALTH HISTORY

A

Thank you for completing this information before your first visit.
It is a confidential part of our patient records.

Exam date _____ Exam time _____

Smith Orthodontics
GERALD E. SMITH D.D.S., M.S.D.
101 West Cascade Way, Suite 100
Spokane, WA 99208
(509) 467-6535 · FAX 467-4507

Patient Information

Your last name _____ First name _____ M.I. _____ Phone _____

Mailing address _____ City _____ State _____ Zip _____

Date of birth _____ Age _____ Sex: ❒ M ❒ F

Other family members under treatment at this office? _____

What is the nature of your dental concern? _____

Whom may we thank for referring you? _____

Responsible Party Information

Last name _____ First name _____ Marital status _____

Residence ❒ Same as patient **or** _____ City _____ State _____ Zip _____

Mailing address ❒ Same as patient **or** _____ City _____ State _____ Zip _____

How long at this address? _____ Home phone _____ Work phone _____

Previous address (if less than 3 years) _____ City _____ State _____ Zip _____

Social security # _____ Date of birth _____ Relationship to patient _____

Employer _____ Occupation _____ No. of years employed _____

Spouse's last name _____ First name _____ Relationship to patient _____

Social security # _____ Date of birth _____ Work phone _____

Employer _____ Occupation _____ No. of years employed _____

Additional Information

We request the following information so we are able to communicate effectively with the people involved in your treatment.

Person to be notified in case of an emergency

Last name _____ First name _____

Relationship to patient _____ Home phone _____ Work phone _____

Residence ❒ Same as patient **or** _____ City _____ State _____ Zip _____

Other persons we should know about

Last name _____ First name _____

Relationship to patient _____ Home phone _____ Work phone _____

Residence ❒ Same as patient **or** _____ City _____ State _____ Zip _____

Dental History

Your dentist _____

Date of last cleaning _____

Has all dental work/fillings been completed ❑ yes ❑ no

Have any members of the family had orthodontic treatment? If yes, who and where

_____

Check if you have or have had:

❑ extra teeth ❑ gum disease or infection

❑ missing teeth ❑ teeth sensitive to hot, cold, or sweets

Check all that apply to you:	Yes	*If yes, please explain*
Prior orthodontic evaluation		Date:
Prior orthodontic treatment		Date:
History of thumb or finger sucking		
Breathes with mouth open		
Extracted teeth		
Had a severe injury to the head, face, or teeth		Date:
Treatment by periodontist, endodontist, or oral surgeon		
Negative or resistant feelings about braces		
Dissatisfied with the appearance of your teeth		

Temporomandibular Joint

Check all that apply to you:	Yes	*If yes, please explain*
Treatment for a jaw joint problem		
History of clenching or teeth grinding		
Jaw joint (TMJ) makes noise or hurts when moving		
Pain in or around the teeth, ears, temples, or cheeks		
Bite feels uncomfortable or unusual		
Frequent headaches		

Transfer Orthodontic Patient

Your orthodontist _____

Address _____

Date of last adjustment _____

Medical History

Your physician _____

Have you:

had unusual growth patterns? ❑ yes ❑ no

inherited family facial or dental characteristics? ❑ yes ❑ no

Check all that apply to you:	Yes	*If yes, please explain*
Current or past medical conditions		List:
Taking any medication(s)		List:
Allergies		List:
Unfavorable reaction to medications		
Any surgery or hospitalizations		
Emotionally, mentally or physically challenged		

Please check any of the following which you have or have had:

❑ Adenoids removed at age_____
❑ Tonsils removed at age_____
❑ AIDS of HIV positive
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bleeding problems
❑ Bone disorders
❑ Cleft lip
❑ Cleft palate
❑ Diabetes
❑ Dizziness
❑ Epilepsy or convulsions
❑ Fainting
❑ Glaucoma
❑ Hearing problems
❑ Heart disease
❑ Heart murmur
❑ Hepatitis
❑ High blood pressure
❑ Hyperactivity
❑ Kidney problems
❑ Latex allergy
❑ Liver problems
❑ Malignances, tumors, cancers
❑ Prosthetic joint (replacement)
❑ Radiation therapy
❑ Rheumatic/Scarlet fever
❑ Speech problems
❑ Thyroid or hormonal imbalance
❑ Tuberculosis
❑ Wears contact lenses

Are there any other dental or medical concerns we should know about?

_____

_____

Signatures

This information is complete and accurate. If any information changes, I will notify Dr. Smith's office immediately. I authorize the release of my records to my insurance company, physician, or dentist as deemed necessary in the professional judgment of my dentist.

_____

Patient signature date

I understand that where appropriate credit reports may be obtained.

_____

Patients signature date