Patient's Full Name _____ Date of Birth _____ Nickname/Preferred Name _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Home Ph _____ Cell Ph _____

Age _____ Gender □ Male □ Female □ Single □ Married □ Widowed □ Separated □ Divorced

Employed by _____ Your Occupation _____

Business Address _____

Business Ph _____ Social Security # _____

Name of Dental Insurance Company _____ Group # _____

Who is financially responsible for this account? (Please provide full name)_____

Relationship to patient_____

Spouse Name _____ Spouse Date of Birth _____

Spouse Employed by _____ Spouse Occupation _____

Business Address _____

Business Phone _____ Social Security # _____

In case of emergency, who should be notified? _____

Relationship to patient _____Phone_____

Names and ages of children, if any _____

Patient's Dentist _____ Patient's Physician _____

Whom may we thank for referring you? _____

Reason for your consultation? _____

DENTAL HISTORY

Date of last dental exam/cleaning _____

Yes No Are you currently in any dental or medical pain?_____

Yes No Did you ever have any of the following habits? Finger/Thumb-Sucking Lip-Sucking Lip-Biting Pacifier

Yes No Did habit occur past the age of four?_____

Yes No Is the habit is still present?_____

Yes No Have there been injuries to the face, mouth, gums or teeth? _____

Yes No Have you ever lost or chipped any teeth?_____

Yes No Is any part of your mouth sensitive to pressure or temperature?_____

Yes No Do your gums bleed when you brush?_____

Yes No Are you a mouthbreather?_____

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?_____

Yes No Are you aware of your jaw clicking or popping?_____

Yes No Do you clench your teeth during the day?_____

Yes No Do you grind your teeth?_____

Yes No Are you aware that some appointments will be during school/work hours?_____

Yes No Has an orthodontist been consulted previously? _____

Yes No Did you have previous orthodontic treatment? _____

MEDICAL HISTORY

Date of last physical_____

Yes No Are you in good health?_____
Yes No Is there a history of a major illness?_____
Yes No Have you ever had any major operations?_____
Yes No Have you ever been involved in a serious accident?_____
Yes No Are you currently under the care of a physician? Please state reason or condition_____
Yes No Do you have any drug allergies or had an adverse reaction to any medication?_____
Yes No Do you have any other allergies?_____
Yes No Are you taking any drugs/medications at this time? (Please list)_____
_____
Yes No Do you need to be pre-medicated (antibiotics) for routine dental procedures?_____

Female patients only:

Yes No Do you suspect that you are pregnant?
Yes No Are you nursing?

Circle any of the conditions below that you have had or currently have.

-ADHD
-Anemia
-Arthritis
-Artificial Heart Valves
-Asthma or Hayfever
-Autoimmune Disease
-Back Problems
-Bipolar
-Blood Disorders
-Bone Disorders
-Cancer
-Chemical Dependency
-Chronic Diarrhea
-Chronic Ringing of Ears
-Circulatory Problems
-Cold Sores
-Diabetes
-Dizziness
-Ear Infections
-Epilepsy
-Gastrointestinal Disorders
-General Allergies
-Headaches
-Heart Problems
-Hemophilia
-Herpes
-Hepatitis
-High Blood Pressure
-HIV/AIDS
-Kidney Problems
-Low Blood Pressure
-Lung Disease
-Nervous Disorders
-Oral Ulcers
-Radiation/ Chemotherapy
-Prolonged Bleeding
-Pneumonia
-Psychiatric Care
-Recent Weight Loss
-Rheumatic Fever
-Sinus Problems
-Smoker
-Sore Throats
-Special Diet
-Stroke
-Swollen Neck Glands
-Tuberculosis
-Tumor or Cancer
-Venereal Disease
-Other_____

Is there anything else we should know about your medical history? _____

Your interest in having treatment is: □ Want treatment □ Willing if necessary □ Unwilling

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph and I also understand that my diagnostic records and name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I will not hold Dr. Lembck or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. In addition, I authorize Dr. Lembck to perform a complete orthodontic evaluation. I understand that where appropriate, credit bureau reports may be obtained.

Date _____ Patient's Signature _____