WELCOME TO OUR OFFICE

PATIENT'S NAME_____SEX: M____ F____

HOME ADDRESS_____CITY_____ZIP CODE_____

AGE_____BIRTHDATE_____HOME PHONE_____

E-mail_____

OCCUPATION_____
Employer_____Business Phone_____

PERSON RESPONSIBLE FOR ACCOUNT_____
If different from patient, Contact Phone_____; Relationship to Patient_____

Status: Single_____, Married_____, Separated_____, Divorced_____, Widowed_____
Name of Spouse_____Spouse's Employer_____
Spouse's Occupation_____Bus. Phone_____
Name/Age of Children_____

BRIEFLY DESCRIBE THE ORTHODONTIC PROBLEM
_____
_____
Describe any previous orthodontic treatment/consultation:_____
Indicate your concern for orthodontic treatment:

Very concerned_____, Concerned_____, Indifferent_____, Opposed_____

Which family member(s) has similar dental or facial problems?_____
Which family member(s) received orthodontic treatment?_____

INSURANCE PLAN WHICH MAY COVER ORTHODONTIC TREATMENT_____
MEMBERSHIP NUMBER_____GROUP NUMBER_____
SUBSCRIBER'S NAME_____ SUBSCRIBER'S BIRTHDATE_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

FAMILY PHYSICIAN_____Approximate Date of Last Exam_____

GENERAL HEALTH IS: excellent_____, good_____, fair_____, poor_____

Are you under any medical treatment now?_____

LIST ANY MEDICATION YOU ARE PRESENTLY USING:_____
_____

FAMILY DENTIST_____Approximate Date of Last Exam_____

ORAL HEALTH IS: good_____, fair_____, poor_____ DO YOU FLOSS DAILY?_____

DO YOU HAVE ANY OF THE FOLLOWING HABITS? (*check all that apply*)

_____Finger/Thumb Habit	_____Lip/Cheek Biting
_____Grinding Teeth	_____Clenching Teeth
_____Mouth Breathing	_____Tongue Thrusting

INTERESTS and HOBBIES_____

(PLEASE CONTINUE ON THE OTHER SIDE)

DR. LILI K. HORTON, D.M.D., S.M.
ORTHODONTIST

PATIENT- PAST AND PRESENT MEDICAL HISTORY:

YES	NO	
( )	( )	Frequent nasal obstruction_____, Earaches_____, Sore Throat_____
( )	( )	Frequent headaches
( )	( )	Temporomandibular joint (TMJ or jaw) pain, noise or dysfunction IF YES, PLEASE ASK FOR OUR TMJ FORM.
( )	( )	Have you had any accidents/trauma to face or teeth? ACCIDENT DATE_____ If yes, please describe:_____
( )	( )	Have you had any serious problems with any previous dental treatment? If yes, please explain:_____ _____
( )	( )	Allergy to: PENICILLIN_____, ASPIRIN_____, Other Drugs_____, METALS (Nickel, Chrominum/etc.)_____, LATEX (Rubber products)_____
( )	( )	Other allergies: Asthma_____, Hayfever_____, Hives_____, Skin Rash_____, Other_____
( )	( )	Sore on lips, in mouth, or on skin (persistent or recurring)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE CHECK ALL THAT APPLY.

_____Anemia	_____Rheumatic Fever
_____Bleeding Problems	_____Rheumatic Heart Disease
_____Diabetes	_____Eye Problems
_____Thyroid Problems	_____Ear/Hearing Problems
_____Respiratory Disease	_____Stomach/Intestinal Disease
_____Cold sores/Canker sores/Herpes	_____Cancer
_____Fainting/Epilepsy/Seizures	_____Liver Disease/Jaundice
_____Emotional Disorders	_____Hepatitis
_____Kidney Disease	_____Tuberculosis (TB)
_____Arthritis	_____HIV/AIDS
_____Bone Disease	_____Venereal Disease (VD)
_____Arteriosclerosis	_____Other Infectious Disease

_____High/Low Blood Pressure *If yes, is it controlled?*_____

_____Heart Problems *If yes, please explain:*_____

DO YOU HAVE ANY DISEASE OR CONDITION NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

IF NO, PLEASE CHECK HERE _____.

IF YES, PLEASE EXPLAIN:_____

_____

FEMALES: Are you pregnant? NO_____ YES_____

PATIENT'S SIGNATURE_____DATE_____