BROOKS
family orthodontics

PATIENT INFORMATION

DATE: _____

DATE OF BIRTH: _____

PATIENT'S NAME: _____ NICKNAME: _____ AGE: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

PATIENT'S DENTIST: _____ REFERED BY: _____ PHYSICIAN: _____

EMAIL: _____ HOME: _____ CELL: _____

ACCOUNT INFORMATION

PERSON RESPONSIBLE: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

DATE OF BIRTH: _____ SOCIAL SEC #: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

SECONDARY RESPONSIBLE: _____ DATE OF BIRTH: _____ SOCIAL SEC #: _____

EMPLOYER: _____ WORK PHONE: _____

ORTHODONTIC INSURANCE: NO: ____ YES: ____ NAME(S) OF COMPANY: _____

INSURED'S NAME: _____ INSURANCE ID NO: _____

OTHER FAMILY MEMBERS IN OUR PRACTICE: _____

MEDICAL HISTORY

IS PATIENT IN GOOD HEALTH? YES ☐ NO ☐ IS PATIENT PRESENTLY UNDER PHYSICIAN'S CARE? YES ☐ NO ☐

Check any of the following for which the patient is now being or has been treated for

DIABETES	☐	ANEMIA	☐	PROLONGED BLEEDING	☐
HEART DISEASE	☐	EPILEPSY	☐	FAINTING/DIZZINESS	☐
RHEUMATIC FEVER	☐	ASTHMA	☐	NERVOUS DISORDERS	☐
BONE DISORDERS	☐	HEPATITIS	☐	PREGNANCY, NOW	☐
GLAUCOMA	☐	HIGH/LOW BP	☐	OTHER	☐

DOES PATIENT HAVE A TENDENCY OF :

COLDS ☐ SORE THROATS ☐ EAR INFECTIONS ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES ☐ NO ☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN: _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY: _____

APPOXIMATE DATE OF LAST DENTAL EXAMINATION: _____

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH, OR TEETH? YES ☐ NO ☐

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? YES ☐ NO ☐ UNTIL WHAT AGE? _____

DOES/DID THE PATIENT BITE LIPS, TONGUE, CHEEKS, OR OTHER OBJECTS? YES ☐ NO ☐

DOES THE PATIENT GRIT GRIND, OR CLENCH TEETH AT NIGHT? YES ☐ NO ☐

REASONS FOR CONSULTATION: _____