Welcome to our office!

Come smile with us!

Patient Information

Date _____

Patient Name _____
Last First Middle

Address _____
Street City State Zip

How long at this address? _____ If less than 3 years-list previous address

Previous Address _____
Street City State Zip

Birthdate _____ Age _____ SS# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ Years Employed _____

Marital Status (Circle One) Single Married Divorced Widowed Separated

Spouse's Name _____ Birthdate _____ Age _____ SS# _____

Employer _____ Occupation _____ Years Employed _____ Work Phone _____

Children _____ Birthdate _____ Age _____ Male or Female

_____ Birthdate _____ Age _____ Male or Female

_____ Birthdate _____ Age _____ Male or Female

List any Family Members who have been or are in treatment in our office _____

Who may we thank for referring you to our office? _____

Hobbies _____

Dental Insurance Information

Insured's Name _____ SS# _____
Last First Middle

Relationship to Patient _____ Birthdate _____

Insured's Employer _____ Work Phone _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____
Street City State Zip

Insurance Phone No _____

Do you have dual insurance coverage? Yes or No If Yes:

Insured's Name _____ SS# _____
Last First Middle

Relationship to Patient _____ Birthdate _____

Insured's Employer _____ Work Phone _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____
Street City State Zip

Emergency Information

Name of nearest relative not living with you _____

Relationship to Patient _____ Home Phone _____ Cell Phone _____

Address _____
Street City State Zip

Carlyle Orthodontics

Specializing in amazing smiles

What main concerns do you want to address with orthodontic treatment? _____

_____

Have you ever been evaluated or had orthodontic treatment before? Yes No

Describe if yes: _____

Name of general dentist: _____ Date of last dental visit: _____

Do you need antibiotic premedication before dental procedures? Yes No

Have you ever experienced any of the following?

Y N Clenching/Grinding Y N Nail Biting Y N Thumb/Finger Sucking

Y N Tongue Thrust Y N Mouth Breathing Until what age? _____

Y N Lip Sucking/Biting Y N Speech Problems Y N Pacifier Habit

Until what age? _____

Do you experience frequent headaches? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

Describe if yes: _____

List any musical instruments played: _____

Have you been informed of any missing or extra permanent teeth? Yes No

Describe if yes: _____

Have you had any pain/tenderness/noises in his/her jaw joint (TMJ/TMD)/ears, temples or cheeks? Yes No

Describe if yes: _____

Have you ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Cancer	Y N Heart Murmur/Heart Problems	Y N Rheumatic/Scarlet Fever
Y N ADD/ADHD	Y N Diabetes	Y N Hemophilia	Y N Tuberculosis
Y N Anemia	Y N Epilepsy/Convulsions	Y N Hepatitis/Jaundice	Y N Tonsillitis/Adenoiditis
Y N Arthritis	Y N Endocrine Problems	Y N Herpes	
Y N Artificial Joints/Valves	Y N Emotional Problems	Y N HIV/AIDS	Y N Tonsils Removed:
Y N Asthma	Y N Frequent Colds or Flu	Y N Kidney/Liver Problems	Age: _____
Y N Blood Disease	Y N Handicaps/Disabilities	Y N Lupus	Y N Adenoids Removed:
Y N Bone Disorders	Y N Hearing Impairment	Y N Mitral Valve Prolapse	Age: _____

If answered yes to any above, please explain: _____

_____

Physician: _____ Ph#: _____ Date Last Visit: _____

Are you currently under the care of a Physician? Yes No

Describe if yes: _____

Please list all medications that you are currently taking: _____

Please list all drugs/materials that you are allergic or sensitive to: _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform the necessary dental services, including x-rays, that I may need.

_____

Signature of Patient **Date**

HEALTH HISTORY UPDATES

Date Reviewed	Reviewed By	List **ANY** Changes To This Form