NEW BRAUNFELS BRACES

## PATIENT INFORMATION

NAME: _____ PREFERRED NAME: _____

BIRTHDATE: _____ AGE: _____ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: _____ CITY: _____ZIP CODE: _____

PHONE: (home) _____ (cell) _____

SCHOOL: _____ GRADE: _____

DENTIST: _____DATE OF LAST VISIT: _____

SIBLINGS: (Name & DOB) _____

HAS THE PATIENT EVER HAD AN ORTHODONTIC EVALUATION BEFORE? ☐ YES ☐ NO IF SO, WHERE? _____

## PARENT/GUARDIAN INFORMATION

NAME: _____ EMAIL: _____

ADDRESS: (home) _____# OF YEARS @ ADDRESS _____

PHONE: (home) _____ (work) _____ (cell) _____

EMPLOYER: _____ # OF YEARS:_____ OCCUPATION: _____

BIRTHDATE: _____ SSN: _____

## INSURANCE INFORMATION

INSURED NAME: _____ EMPLOYER: _____

BIRTHDATE: _____ INSURANCE COMPANY: _____

INSURANCE PHONE NUMBER: _____ INSURANCE ID NUMBER: _____

GROUP NUMBER: _____ CLAIMS ADDRESS: _____

_____

## EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

CONTACT PHONE NUMBER: _____ EMAIL: _____

## ADDITIONAL INFORMATION

**WHAT IS YOUR CHIEF CONCERN?** _____

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

**Retention of Documents Relating to Patient Care.** By signing this, you understand and agree that it is our policy to scan and store original documents in electronic form. Further, you agree that any agreement bearing a scanned signature, which is printed in electronic form, has the same force and effect as the original document.

**NAME** _____ **SIGNATURE** _____ **DATE** _____

(OVER)

## DENTAL HISTORY

**CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:**

☐ Blisters on lips/mouth
☐ Broken fillings
☐ Burning sensation, tongue
☐ Chews on tongue
☐ Dry mouth
☐ Extracted teeth
☐ Finger/thumb habits
☐ Food trapped between teeth
☐ Grinding teeth
☐ Gums bleeding
☐ Gums sore/swollen
☐ Injuries to teeth/jaw
☐ Injuries to face/head
☐ Jaw clicking/popping
☐ Jaw locking open/closed
☐ Jaw pain/tenderness
☐ Jaw surgery
☐ Lip/cheek biting
☐ Loose teeth (other than baby teeth)
☐ Mouth breathing
☐ Mouth pain when brushing
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Periodontal surgery
☐ Sensitivity to hot or cold
☐ Sensitivity to sweets
☐ Sensitivity to pressure
☐ Sores/growths in mouth
☐ Speech problems
☐ Tongue thrust

HOW OFTEN DOES THE PATIENT BRUSH? _____ FLOSS? _____

ADDITIONAL COMMENTS: _____

## MEDICAL HISTORY

**CHECK IF THE PATIENT CURRENTLY HAS OR HAS HAD ANY OF THE FOLLOWING:**

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial heart valves
☐ Artificial joints
☐ Asthma
☐ Back problems
☐ Blood diseases
☐ Bone disorders
☐ Cancer
☐ Chemical dependency
☐ Chemotherapy
☐ Circulatory problems
☐ Cortisone treatment
☐ Coughing - persistent
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart murmur
☐ Heart problems
☐ Hepatitis
☐ High blood pressure
☐ HIV Positive
☐ Kidney disease
☐ Liver disease
☐ Mitral valve prolapse
☐ Nervous system problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation treatment
☐ Respiratory disease
☐ Scarlet fever
☐ Shortness of breath
☐ Stroke
☐ Stomach ulcers
☐ Swelling of feet
☐ Thyroid problems
☐ Tobacco habit
☐ Tonsillitis
☐ Tonsils removed
☐ Tuberculosis
☐ Urinary problems
☐ Other (not listed) _____

**FEMALES ONLY** IS IT POSSIBLE THE PATIENT IS PREGNANT? ☐ YES ☐ NO

IS THE PATIENT UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

FOR WHAT CONDITION? _____

PHYSICIAN'S NAME: _____

PHONE: _____

**MEDICATIONS**

Please list **ANY & ALL** medications the patient is currently taking:

_____

_____

**ALLERGIES**

Please list **ANY & ALL** known allergies you are aware of (EXAMPLE(S): Latex, Metal, Medications):

_____

IS THE PATIENT CURRENTLY TAKING OR HAS TAKEN ANY BONE DENSITY MEDICATIONS? ☐ YES ☐ NO
(Aclasta, Actonel, Actonel+Ca, Aredia, Atelvia, Binosta, Bonefos, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, or Zometa)

The above information is accurate and complete to the best of my knowledge and is only for use in my child's treatment. It is my responsibility to inform this office of any changes in my child's personal information or health status. I will not hold this office, our doctors or our staff responsible for any errors or omissions that I have made in the completion of this form.

**NAME** _____ **SIGNATURE** _____ **DATE** _____