WELCOME
TO OUR PRACTICE

ANDREWS ORTHODONTICS
smiles that EMPOWER.

PATIENT INFORMATION

Title (check one) ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Patient's Name _____ Email _____
First Last
Sex ☐ M ☐ F D.O.B _____ Age _____ SS# _____ Preferred Name _____
☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced Student Attending _____ Major _____
Cell# _____ Home# _____ Work# _____
Residence _____
Street City Zip
Previous Residence _____
(If less than 3 years) Street City Zip
Employer _____ How long at current job? _____
Job Title _____

Dental insurance w/Orthodontic coverage ☐ Y ☐ N
Other family seen by us _____
Child(ren) name and age _____
Hobbies or Interests? _____

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SPOUSE INFORMATION

Name _____ Email _____
First Last
Cell# _____ Home# _____ Work# _____
D.O.B _____ SS# _____ Job Title _____
Employer _____ How long at current job? _____
Job Title _____

DENTAL INFORMATION

General Dentist _____ Date of last visit _____
What would you love to change about your smile? _____
_____

Have you ever been evaluated for, or received orthodontic treatment?	☐ Yes ☐ No	Date _____
Have you ever been informed of any missing or extra permanent teeth?	☐ Yes ☐ No	
Have you ever been had a problem with previous dental work?	☐ Yes ☐ No	
Have you ever broken or chipped any teeth?	☐ Yes ☐ No	
Any serious injury to the face, mouth, or chin?	☐ Yes ☐ No	
Have you ever experienced pain or discomfort in your jaw joint (TMJ)?	☐ Yes ☐ No	

CONTINUED ON BACK

HEALTH HISTORY

Please list all medications you are currently taking _____

_____

Please list all medications/substances that you are allergic to _____

_____

Check any of the following conditions you have (or have had) in the past

☐ Autism Spectrum Disorders	☐ Heart Murmur/Problems	☐ Asthma/Hay Fever/Sinus Problems	☐ Diabetes
☐ ADD/ADHD	☐ High/Low Blood Pressure	☐ Difficulty breathing	☐ Epilepsy
☐ Depression/Anxiety	☐ Abnormal Bleeding	☐ Gastro disorders	☐ Herpes/Fever Blister
☐ Nervous Disorders	☐ Anemia	☐ Arthritis	☐ Kidney Problems
☐ Handicap/Disability	☐ Dizziness	☐ Bone Disorders/Osteoporosis	☐ Hepatitis
☐ Other (Please detail below)	☐ Headaches/Migraines	☐ Congenital Heart Defect	☐ HIV/AIDS

Have you had your tonsils or adenoids removed? ☐ Y ☐ N If yes, what age? _____

Residence _____

Previous Residence _____

Employer _____ How long at current job? _____

Job Title _____

List any serious illness (physical or mental) not mentioned above _____

_____

_____

Any medical conditions that we have not discussed that we should be aware of? ☐ Y ☐ N

If yes please explain _____

_____

I have truthfully answered all questions and agree to inform this office of any changes in my medical and dental history. In addition, I authorize the Andrews Orthodontics dream team to perform all necessary dental services that may be needed during diagnosis and treatment with my informed consent.

Signature _____ Date_____

DOCTOR NOTES