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 members seen by us _____

Child(ren) name and age _____

Hobbies or Interests? _____

SPOUSE INFORMATION

Name _____ Email _____
First Last

Cell# _____ Home# _____ Work# _____

D.O.B _____ SS# _____ Job Title _____

Employer _____ How long at current job? _____

INSURANCE SUBSCRIBER INFORMATION

☐ SAME AS PATIENT INFO ☐ SAME AS SPOUSE INFO

Name _____ D.O.B _____ SS# _____
First Last

Residence _____

Employer _____

CONTINUED ON BACK

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 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

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? _____

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

_____

_____

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