BROCK Orthodontics

Orthodontics & Dentofacial Orthopedics

Katy West
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Katy, TX 77494
(346) 387-6289

Orthodontic Information Form

Welcome to our practice
The information on this form will be kept confidential.

PATIENT INFORMATION

Patient Name:_____
First Middle Last Nickname

Birthdate:___/_____/___ Age:_____ ☐Male ☐ Female

Home Phone:_____-_____-_____ School:_____

Address:_____
street city/state zip code

Physician:_____ Phone:_____-_____-_____

Dentist:_____ Phone:_____-_____-_____

If patient is a minor, please give parent/guardian names:

May we contact you at work?

Mother:_____ Work Phone _____Ext:_____ ☐ Yes ☐ No

Father:_____ Work Phone_____Ext:_____ ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION

Name:_____

Address:_____
street city/state zip code

Relationship to patient:_____

Employer:_____ Birthdate:___/____/____ SSN:_____

EMERGENCY INFORMATION

Name of nearest relative, not living with you:_____ Phone:___-___-____

Address:_____
street city/state zip code

How did you hear about our office? (Please feel free to check more than one)

☐ Another patient ☐ Dentist/Professional ☐ Employee of this office

☐ Transfer ☐ Advertisement ☐ Other:_____

Whom may we thank for referring you?

Member American Association of Orthodontists

DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

Office use only
Date:_____ Pt#:_____
Rec:_____ Lett:_____

Dental History

Why have you come to the orthodontist today?

_____

Do you like your smile? Y N
Are you currently in pain? Y N
Your current dental health is: Good Fair Poor
Are you currently taking fluoride supplements? Y N
Do your gums bleed when brushing? Y N
Any history of discomfort in jaw joint (TMJ/TMD)?
Y N Explain:_____
# of times per week you floss:_____
# of times per day you brush:_____
Type of bristle used: Hard Medium Soft

Medical History

Your current medical health is: Good Fair Poor
Are you currently under the care of a physician?
Y N Explain:_____
Are you taking prescription drugs? Y N

FOR WOMEN ONLY

Are you pregnant? Y N
Are you taking birth control pills? Y N
Are you nursing? Y N

FOR CHILDREN/ADOLESCENTS

Do you or have you had any of the following habits?
Y N Thumb/Finger Sucking
Y N Lip Sucking/Biting
Y N Nail Biting
Y N Other:_____

Have you ever had any of the following diseases or medical problems?

Y N Prosthesis Y N Scarlet Fever
Y N Heart Attack Y N Heart Conditions
Y N Rheumatic fever Y N Convulsion/Epilepsy
Y N Mitral Valve Prolapse Y N Abnormal Bleeding
Y N Heart Murmur Y N Diabetes
Y N Heart Surgery Y N Artificial Valves
Y N Hemophilia Y N Stays in Hospital
Y N Blood Transfusion Y N Hi/Lo Blood Press.
Y N Cancer Y N Ulcers Colitis
Y N Kidney/Liver problems Y N Hepatitis
Y N Fever Blister Y N Shingles
Y N HIV/AIDS Y N STD
Y N Difficulty Breathing Y N Asthma
Y N Emphysema Y N Sinus Problems
Y N Hearing Impairment Y N Sev/Freq Headaches
Y N Glaucoma Y N Tuberculosis
Y N Anemia/Iron def. Y N Radiation Treatment
Y N Other:_____

Are you Allergic to any of the following?

Y N Aspirin Y N Ibuprofen (Advil)
Y N Acetaminophen(Tylenol) Y N Naproxen
Y N Codeine Y N Erythromycin
Y N Penicillin Y N Tetracycline
Y N Latex Y N Metals
Y N Other:_____

Please list all drugs currently taken by the patient:
_____
_____
Please list all drugs the patient is allergic to:
_____
_____

I attest that the information I have given is correct to the best of my knowledge and understand that it will be held in the strictest confidence. I further acknowledge that it is my responsibility to inform this office of any changes in my child's medical status in a timely manner. I authorize the dental staff to perform the necessary dental services needed by my child.

_____
Signature of parent Date

Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian/patient named herein.
Initials:_____ Date:_____ Comments:_____
Update1 Initials:_____ Date:_____ Comments:_____
Update2 Initials:_____ Date:_____ Comments:_____