BELLEVUE FAMILY ORTHODONTICS

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Thank you for your cooperation.
This information is kept confidential.

Patient Information — PLEASE PRINT LEGIBLY

PATIENT'S NAME LAST	FIRST	MIDDLE	TODAY'S DATE
BIRTHDATE / /	GENDER ☐ MALE ☐ FEMALE	PREFERRED NAME	
STREET ADDRESS	CITY	STATE	ZIP
PHONE NUMBER (mom or dad's please cirlce)	EMAIL		
PATIENT'S DENTIST (NAME AND CITY)	WHOM MAY WE THANK FOR REFERRING YOU?		
IF PATIENT IS A MINOR, **Mom's Full Name:**	**Dad's Full Name:**		
Mom prefers to go by:	*Dad prefers to go by:*		
WHO ELSE MAY BRING PATIENT TO APPOINTMENTS (AND RELATIONSHIP TO PATIENT)			

Responsible Party Information

NAME LAST	FIRST	MIDDLE	MARITAL STATUS
BIRTHDATE / /	SOCIAL SECURITY #	RELATIONSHIP TO PATIENT	
MAILING ADDRESS	CITY	STATE	ZIP
HOW LONG AT THIS ADDRESS ☐ RENT ☐ OWN	HOME PHONE NUMBER	WORK PHONE NUMBER	
EMPLOYER	OCCUPATION	YEARS EMPLOYED	

Primary Dental Insurance

SUBSCRIBER'S NAME	BIRTHDATE / /	EMPLOYER
INSURANCE COMPANY NAME	ID #	GROUP#
INSURANCE ADDRESS		PHONE NUMBER

Secondary Dental Insurance

SUBSCRIBER'S NAME	BIRTHDATE / /	EMPLOYER
INSURANCE COMPANY NAME	ID #	GROUP#
INSURANCE ADDRESS		PHONE NUMBER

Emergency Information

NAME		PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP

I understand that, where appropriate, credit bureau reports may be obtained.
Financially responsible person(s) will be asked to sign the financial agreement before treatment begins.

Signature (Parent or Guardian if patient is a minor) **X**____

Patient Health History

PLEASE PRINT LEGIBLY

PATIENTS NAME LAST	FIRST	MIDDLE	TODAY'S DATE:
PHYSICIAN'S NAME	PHYSICIAN'S LOCATION (CITY)		DATE OF LAST VISIT TO PHYSICIAN

DO YOU CURRENTLY HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS? ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

NO.	CONDITION	YES	NO	DON'T KNOW	NO.	CONDITION	YES	NO	DON'T KNOW
1.	Allergies or drug reactions	○	☐	○	19.	Hormone disorder	○	☐	○
2.	Arthritis (rheumatoid, other)	○	☐	○	20.	Drug abuse (including alcohol)	○	☐	○
3.	Asthma	○	☐	○	21.	Kidney disorders	○	☐	○
4.	AIDS or positive HIV test	○	☐	○	22.	Liver disorders	○	☐	○
5.	Back pain	○	☐		23.	Lung disorders	○	☐	○
6.	Bleeding - prolonged	○	☐	○	24.	Nose / throad disorder	○	☐	○
7.	Blood disorder	○	☐	○	25.	Replacement heart valve	○	☐	
8.	Blood pressure - high or low	○	☐	○	26.	Replacement joint	○	☐	
9.	Cancer / tumor	○	☐	○	27.	Rheumatic fever	○	☐	○
10.	Diabetes	○	☐	○	28.	Stomach disorders	○	☐	○
11.	Emotional problems	○	☐	○	29.	Stroke	○	☐	○
12.	Epilepsy	○	☐	○	30.	Tonsils / adenoids removed	○	☐	○
13.	Eye problems (glaucoma, other)	○	☐	○	31.	Tuberculosis	○	☐	○
14.	Fainting or dizzy spells	○	☐		32.	Thyroid disorder	○	☐	○
15.	Hepatitis / hepatitis carrier	○	☐	○	33.	Venereal disease	○	☐	○
16.	Heart murmur	○	☐	○	34.	Are you taking any medications?	○	☐	
17.	Heart disorders - other	○	☐	○	35.	Other (describe below)	○	☐	
18.	Smoking	○	☐						

IF PATIENT IS A MINOR FEMALE, HAS SHE HAD HER FIRST MENSTRUAL CYCLE? (This information will help in growth forecasting.) ○ YES ☐ NO

Patient Dental History

DENTIST'S NAME	DENTIST'S LOCATION (CITY)	DATE OF LAST VISIT TO DENTIST
FREQUENCY OF DENTAL CHECKUPS ○ TWICE A YEAR ○ ONCE A YEAR	○ ONLY IF THERE'S A PROBLEM ○ NEVER	FREQUENCY OF FLOSSING EACH WEEK?

DO YOU CURRENTLY HAVE OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS? ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE.

NO.	CONDITION	YES	NO	DON'T KNOW	NO.	CONDITION	YES	NO	DON'T KNOW
36.	Allergy to dental injections	○	☐	○	49.	Jaw locking open or closed	○	☐	○
37.	Anxious about dental treatment	○	☐	○	50.	Mouth breathing / difficult nose breathing	○	☐	○
38.	Bleeding gums	○	☐	○	51.	Noise or clicking in jaw	○	☐	○
39.	Clenching	○	☐	○	52.	Periodontal disease (gum disease)	○	☐	○
40.	Previous thumb / finger-sucking habit	○	☐	○	53.	Permanent teeth - extracted	○	☐	○
41.	Current thumb/finger-sucking habit	○	☐	○	54.	Previous orthodontic treatment	○	☐	○
42.	Dental surgery	○	☐	○	55.	Recurring tooth pain	○	☐	○
43.	Difficulty chewing or swallowing	○	☐	○	56.	Sores in mouth	○	☐	○
44.	Excessive snoring	○	☐	○	57.	Speech problems	○	☐	○
45.	Frequent headaches or face pain	○	☐	○	59.	Unfinished dental treatment	○	☐	○
46.	Grinding (bruxing) teeth	○	☐	○	60.	Unusual growth pattern	○	☐	○
47.	Injury to head, neck, or teeth	○	☐	○	61.	Other (describe below	○	☐	○
48.	Jaw Pain	○	☐	○					

FOR ANY "YES" ANSWERS ABOVE, PLEASE LIST THE QUESTION NUMBER AND DESCRIBE THE CONDITION (USE BACK OF PAGE IF NEEDED)

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I CERTIFY THE INFORMATION ON THIS FORM TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT / PARENT / GUARDIAN	DATE	DOCTOR REVIIEW	DATE
X			