MOUNTAIN VIEW ORTHODONTICS

MEDICAL AND DENTAL HISTORY

Today's date:	Reason for visit (chief concern):

PATIENT INFORMATION

Patient's First Name:	**Last Name:**	Middle:	Birth date:	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:	Home phone number: Cell phone #:		
P.O. box:	City:	State:	ZIP Code:		
How did you hear about us?					
Name of Patient's Dentist:	Dentist's Phone Number:	Dentist's Address:			
Date Last Seen by Dentist and Reason:		Physician Name and Phone Number:			
Other Family Members Seen Here:		Your email address:			

FAMILY INFORMATION (IF PATIENT IS A MINOR)

Responsible Party:		Relationship to Patient (eg Mom, Stepmom, Guardian, Other):	
Address:	Home phone:	Work phone:	SS#:
Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Widowed ( ) Divorced If Divorced, custodial parent name:			
Employer:	Occupation:	Employer Address:	No. years employed:
Spouse's Name:	Spouse's Relationship to Patient: ( ) Mom ( ) Dad ( ) Stepmom ( ) Stepdad ( ) Other If Other, please explain:		
Spouse's Employer:	Spouse's Occupation:	Employer Address:	No. years employed:
Birth Father's Height :	Birth Mother's Height:	Patient's Current Height and Weight:	
Other family members seen here:		Number of brothers/sisters and their age:	
Patient Attends School at:	Musical Instruments Played, Hobbies:		Grade:

INSURANCE INFORMATION

(Please complete and give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	
Home Phone (if different):	Cell Phone:	E-mail Address:	Relationship to patient:
Occupation:	Employer:	Employer address:	Employer phone Number:

Is this patient covered by insurance?
❑ Yes
❑ No

Primary Dental Insurance:	Policy Holder's name:			Policy Holder's S.S. no.:
Insurance Co Phone/Address:	Policy Holder's Employer:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary Dental Insurance (if applicable):	Policy Holder's name:			Policy Holder's S.S. no.:
Insurance Co Phone/Address:	Policy Holder's Employer:	Birth Date:	Group no.:	Policy no.:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

Patient Medical History

Now, or in the past, has the patient had?

Allergies to medications?	❑yes	❑no	Allergies to Latex or Plastics?	❑yes	❑no
Other Allergies?	❑yes	❑no	Endocrine or Thyroid problems?	❑yes	❑no
Birth defects?	❑yes	❑no	Heart Problems?	❑yes	❑no
Diabetes?	❑yes	❑no	Cancer?	❑yes	❑no
Blood or bleeding disorder?	❑yes	❑no	Epilepsy or Seizures?	❑yes	❑no
Disabilities?	❑yes	❑no	AIDS or HIV positive?	❑yes	❑no
Asthma?	❑yes	❑no	Hepatitis or Liver problems?	❑yes	❑no
Mental Health Disturbances?	❑yes	❑no	High or Low Blood Pressure?	❑yes	❑no
ADD / ADHD?	❑yes	❑no	Autism?	❑yes	❑no
Rheumatoid or Osteoarthritis?	❑yes	❑no	Injuries to face, mouth, or chin?	❑yes	❑no
Tonsils or Adenoids removed?	❑yes	❑no	Prosthetic joints or pacemaker?	❑yes	❑no
Major Operations?	❑yes	❑no	Kidney disorders?	❑yes	❑no
Strep infections?	❑yes	❑no	Rheumatic Fever?	❑yes	❑no
Ear, Nose, or Throat condition?	❑yes	❑no	Frequent Headaches?	❑yes	❑no
Fainting or neurologic problem?	❑yes	❑no	Tuberculosis?	❑yes	❑no
History of eating disorder?	❑yes	❑no	Osteoporosis?	❑yes	❑no
Use of tobacco?	❑yes	❑no	History of substance abuse?	❑yes	❑no

Please explain any "yes" answers: _____

_____

_____

Please list any medications being taken and reason, and also any significant past use of medications:

Be sure to inform us if there is any current or past use of bisphosphonates. Bisphosphonates are a type of medication that can significantly impact orthodontic treatment. Some of the brand names are Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, and Zometa.

Dental History

Now, or in the past, has patient had?

"Extra" or missing teeth?	❑yes	❑no	Chipped or injured teeth?	❑yes	❑no
Sensitive or painful teeth?	❑yes	❑no	Jaw fractures or cysts?	❑yes	❑no
Root canal treatment?	❑yes	❑no	Periodontal "gum" problems	❑yes	❑no
Frequent mouth sores?	❑yes	❑no	Oral Surgery?	❑yes	❑no
Loose or broken fillings?	❑yes	❑no	Any teeth irritating tongue/cheek?	❑yes	❑no
Pain/soreness of facial muscles?	❑yes	❑no	Grinding or clenching of teeth?	❑yes	❑no
Pain, clicking or locking of jaw?	❑yes	❑no	Difficulty opening jaw?	❑yes	❑no
History of "TMJ" or "TMD"?	❑yes	❑no	Ear pain or ringing in ears?	❑yes	❑no

Please explain any "yes" answers:_____

_____

Is antibiotic premedication needed for dental visits? ❑yes ❑no

Please carefully try to remember any significant dental history or any past traumatic events to face, chin, or teeth and describe:

_____

_____

Please describe any family history of jaw imbalances, jaw surgery, or other unusual dental problems:

_____

Habits

Now, or in the past, has patient had?

History of thumb/finger sucking	❑yes	❑no	Tongue thrusting?	❑yes	❑no
Nail biting or object biting?	❑yes	❑no	Mouth breathing?	❑yes	❑no
Speech problems?	❑yes	❑no	Abnormal swallowing?	❑yes	❑no

Describe oral hygiene habits (brush/floss how many times/day): _____

Women Only

Are you pregnant?	❑yes	❑no
Do you anticipate becoming pregnant?	❑yes	❑no

For Girls Only			**For Boys Only**		
Has menstruation begun?	❑yes	❑no	Has voice changed?	❑yes	❑no
If yes, date: _____			If yes, date: _____		
Does child follow directions well?	❑yes	❑no	Does child follow directions well?	❑yes	❑no

Have you seen an orthodontist previously? ❑yes ❑no If yes, please explain:_____

Have any xrays been taken recently? ❑yes ❑no If yes, explain type and date taken:_____

Anything else significant that you feel we should know?

_____

The above information is true to the best of my knowledge. I authorize Mountain View Orthodontics, LLC or my insurance company to release information to check my benefits and I understand, where appropriate, credit bureau reports may be obtained. I give consent to examination by the doctor and staff of Mountain View Orthodontics, LLC.

Patient or Parent/Guardian Signature Date