DANIEL A AVANT ORTHODONTICS DDS MSD PC

"Orthodontics for Adults and Children"

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PATIENT (ADULT)

Patient's Name _____ Appointment Date _____

Name Patient goes by _____ Referred by _____

Home Address _____ Zip Code _____

Home Phone _____ Birthdate _____ Age _____ Sex _____

Employer _____ Address _____ Phone _____

Patient's Physician _____ Patient's Dentist _____

Spouse's Name (if married) _____ Email Address _____

Patient's Hobbies and Interests _____

Have any members of your family had orthodontics treatment at this office? Yes ☐ No ☐

If Yes, list names _____

Person responsible for account _____ Phone _____

Address _____

Are you covered by dental insurance that provides for orthodontics treatment? Yes ☐ No ☐

Insured's Name _____ Date of Birth _____ Social Security / ID # _____

Employer _____ Occupation _____

Business Address _____

Insurance Carrier _____

Insurance Carrier's Address _____ Insurance Carrier's Phone _____

DENTAL HISTORY

Date of Last Dental Visit: _____ Procedures Performed: _____

Your reason for seeking orthodontic treatment _____

Does patient have pain in face/mouth? Yes ☐ No ☐ If Yes, please describe _____

Has patient had blows or injuries to face/mouth? Yes ☐ No ☐ If Yes, please describe _____

Has patient been seen by another orthodontist? Yes ☐ No ☐ If Yes, describe treatment _____

Has patient had TMJ Treatment (jaw joints)? Yes ☐ No ☐

Is there difficulty breathing through nose (mouth breather)? Yes ☐ No ☐

Does patient have speech problems? Yes ☐ No ☐

Does patient have swallowing problems? Yes ☐ No ☐

MEDICAL HISTORY

Is patient in good health? Yes ☐ No ☐

Is patient under physician's care? Yes ☐ No ☐ If Yes, for what reason? _____

_____

Is patient taking medications? Yes ☐ No ☐ If Yes, please list: _____

_____

Is patient allergic to medications? Yes ☐ No ☐ If Yes, please list: _____

_____

Has patient undergone X-ray treatment for tumors, growths or other conditions of the head or neck? Yes ☐ No ☐

If Yes, please describe: _____

Has patient been hospitalized, had a serious illness, or an accident within the last 5 years? Yes ☐ No ☐

If Yes, please describe: _____

Has patient had counseling, psychotherapy, or psychoanalysis? Yes ☐ No ☐

If Yes, please describe: _____

Does patient wear contact lenses? Yes ☐ No ☐

Has patient had tonsils or adenoids removed? Yes ☐ No ☐

Has patient had, or does patient currently have, any of the following?

☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Stomach Ulcers
☐ Allergies	☐ Epilepsy	☐ Hormone Disorder	☐ Tuberculosis
☐ Arthritis	☐ Fainting	☐ Kidney Problems	☐ Venereal Disease/AIDS
☐ Asthma	☐ Convulsions	☐ Liver Problems	☐ Other disorders/diseases:
☐ Bone Disorder	☐ Glaucoma	☐ Prolonged Bleeding	
☐ Cancer/Leukemia	☐ Heart Problems	☐ Rheumatic Fever	_____
☐ Osteoporosis	☐ Osteopenia	☐ Sinus Problems	

This dental and medical history has been completed to the best of my knowledge.
Signature of person completing form (Parent if patient is a minor)

_____ Date _____

HISTORY UPDATE (Office Use Only)

History Update (Office Use Only)

_____ _____

_____ _____

_____ _____

_____ _____