



PINE TOP
ORTHODONTICS
russell h. ford, dmd, ms

Date: _____

PATIENT INFORMATION

Patient's Name: _____
Last First Middle
Address: _____
Street City State Zip
Home Phone: _____ Birthdate: _____ Age: _____
Who is your General Dentist?: _____
How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle Marital Status
Relationship to Patient: _____
Residence (if different from above): _____
Street City State Zip
How long at this address? _____ Home Phone: _____ Work Phone: _____
Mailing Address (if different from above): _____
Street City State Zip
Employer: _____ Occupation: _____ No. Years Employed: _____
Spouse: _____
Last First Middle
Relationship to Patient: _____
Employer: _____ Occupation: _____ No. Years Employed: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ SS or ID #: _____ Birthdate: _____
Insurance Co.: _____ Group #: _____ Telephone #: _____
Insurance Co. Address: _____
Street City State Zip
Insured's Employer: _____
Do you have dual coverage? Yes No If yes:
Insured's Name: _____ SS or ID #: _____ Birthdate: _____
Insurance Co.: _____ Group #: _____ Telephone #: _____
Insurance Co. Address: _____
Street City State Zip
Insured's Employer: _____

(Continued on back)

DENTAL HISTORY

What are the main goals you would like orthodontics to accomplish?

How many months has it been since your last dental check-up? _____

Have you ever had a negative dental experience? Y N

Your current dental health is: Good Fair Poor

Do you like your smile? Y N

Do your gums ever bleed? Y N

Have you been evaluated or had orthodontic treatment? Y N

Have you ever injured your face, mouth, teeth or chin? Y N

Have your adenoids or tonsils been removed? Y N

Do you have any missing, extra, or impacted teeth? Y N

Have you ever had any pain or tenderness in your jaw joint (TMJ/TMD)? Y N

Do you have any speech problems?: Y N

Are you taking any prescription or OTC drugs? Y N

If yes, please list each one: _____

Have you ever taken bisphosphonate drugs (Fosamax, Boniva, etc. used to treat osteoporosis or multiple myeloma)? Y N

HABITS

Did you or do you have any of the following habits?:

Clenching/Grinding teeth Y N Nursing bottle habits Y N

Lip sucking/biting Y N Thumb/Finger sucking Y N

Mouth breather Y N Tongue thrust Y N

Nail biting Y N

Please elaborate on any dental or orthodontic concerns and any additional medical concerns: _____

Signature (Parent/Guardian if minor): _____ Date: _____

Reviewed by Dr. Ford: _____ Date: _____

MEDICAL HISTORY

Current Physician? _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Have you ever had any of the following medical problems?

Abnormal bleeding Y N Handicaps/Disabilities Y N

Artificial Bones/Joints Y N Hearing impairment Y N

Arthritis Y N Heart problems Y N

Asthma Y N Hepatitis Y N

Blood Pressure problems Y N HIV+/AIDS Y N

Cancer/Chemo/Radiation Y N Kidney/Liver defects Y N

Chicken Pox Y N Mitral Valve Prolapse Y N

Convulsions/Epilepsy Y N Psychiatric Treatment Y N

Diabetes Y N Rheumatic/Scarlet fever Y N

Difficulty Breathing Y N Shingles Y N

Fainting Spells Y N Sinus Problems Y N

Fever Blisters/Cold Sores Y N Tuberculosis Y N

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N

If yes, Week #: _____

Are you nursing? Y N

Are you allergic to any of the following?:

Aspirin Y N Latex Y N

Any metals Y N Penicillin Y N

Codeine Y N Tetracycline Y N

Dental Anesthetics Y N Erythromycin Y N

Other: _____

