STIEG & WACHTEL
ORTHODONTICS

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PATIENT INFORMATION

LAST NAME:	FIRST NAME, MIDDLE INITIAL:	NICKNAME:	SEX:	BIRTHDATE:	AGE:

MAILING ADDRESS:	CITY:	STATE:	ZIP:	HOME PHONE:

EMAIL ADDRESS:	FAX:	WORK PHONE:	CELL PHONE:

SCHOOL (IF STUDENT):	GRADE:	HAVE YOU SEEN ANOTHER ORTHODONTIST?

EMPLOYER:	OCCUPATION:

GENERAL DENTIST:	WHO MAY WE THANK FOR THE REFERRAL?

WHY IS THE PATIENT SEEKING ORTHODONTIC TREATMENT?	WHEN DID THE PATIENT FIRST BECOME AWARE OF THE PROBLEM?

PLEASE LIST ANY SPECIAL INTERESTS (SPORTS, HOBBIES, PASTIMES, ETC.):

PARENT INFORMATION (IF PATIENT IS MINOR)

FATHER'S NAME:			MOTHER'S NAME:		
ADDRESS (IF DIFFERENT FROM PATIENT):			ADDRESS (IF DIFFERENT FROM PATIENT):		
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:		HOME PHONE:	CELL PHONE:	
EMPLOYER:	WORK PHONE:		EMPLOYER:	WORK PHONE:	
OCCUPATION:			OCCUPATION:		
EMAIL ADDRESS:			EMAIL ADDRESS:		

PATIENT LIVES WITH:
❑ BOTH PARENTS ❑ MOTHER ❑ FATHER # OF BROTHERS____ AGES_____ # OF SISTERS____ AGES_____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THE ACCOUNT

RESPONSIBLE PARTY:	RELATIONSHIP TO PATIENT:	EMPLOYER/OCCUPATION:

ADDRESS (IF DIFFERENT FROM PATIENT):	CITY:	STATE:	ZIP:

HOME PHONE:	CELL PHONE:	WORK PHONE:

BIRTHDATE:	SSN:	EMAIL ADDRESS:

PRIMARY DENTAL INSURANCE INFORMATION

INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:	

INSURANCE COMPANY PHONE:	GROUP POLICY #:	INSURED'S EMPLOYER:

PRIMARY INSURED'S DATE OF BIRTH:	INSURED'S SSN or MEMBER ID:	INSURED'S RELATIONSHIP TO PATIENT:

SECONDARY DENTAL INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE COMPANY NAME:	INSURANCE COMPANY ADDRESS:	

INSURANCE COMPANY PHONE:	GROUP POLICY #:	INSURED'S EMPLOYER:

INSURED'S DATE OF BIRTH:	INSURED'S SSN or MEMBER ID:	INSURED'S RELATIONSHIP TO PATIENT:

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAMINATION:	CURRENT HEIGHT:	CURRENT WEIGHT:
IS THE PATIENT CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF SO, WHY?		
IS THE PATIENT TAKING MEDICATION NOW? IF SO, FOR WHAT?		

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
DIABETES	❑	❑	TUBERCULOSIS	❑	❑	ENDOCRINE PROBLEMS	❑	❑
PNEUMONIA	❑	❑	ANEMIA	❑	❑	PROLONGED BLEEDING	❑	❑
HEART PROBLEMS	❑	❑	EPILEPSY	❑	❑	LIVER PROBLEMS	❑	❑
RHEUMATIC FEVER	❑	❑	ASTHMA	❑	❑	FAINTING OR DIZZINESS	❑	❑
BONE DISORDERS	❑	❑	KIDNEY PROBLEMS	❑	❑	NERVOUS DISORDER	❑	❑
HEPATITIS	❑	❑	THYROID PROBLEMS	❑	❑			

DOES THE PATIENT OFTEN HAVE: ❑ COLDS ❑ SORE THROATS ❑ EAR INFECTIONS

DOES THE PATIENT HAVE ANY DIFFICULTY IN BREATHING THROUGH THE NOSE? ❑ YES ❑ NO

HAS THE PATIENT'S TONSILS AND ADENOIDS BEEN REMOVED? ❑ YES ❑ NO IF YES, AT WHAT AGE?

PLEASE LIST ANY ALLERGIES OR DRUG SENSITIVITIES

PLEASE DESCRIBE ANY PRESENT OR PAST MEDICAL PROBLEMS, HOSPITALIZATIONS OR OPERATIONS:

DOES THE PATIENT HAVE ANY SPECIAL PROBLEMS THAT HAVE NOT BEEN MENTIONED ABOVE?

DENTAL HISTORY

WHEN DID THE PATIENT LAST VISIT THE DENTIST?	WERE X-RAYS TAKEN?

HAS THE PATIENT HAD ANY INJURIES TO THE FACE, MOUTH OR TEETH? ❑ YES ❑ NO

DOES THE PATIENT PLAY A MUSICAL INSTRUMENT? ❑ YES ❑ NO

HAS THE PATIENT HAD ANY TEETH (BABY OR PERMANENT) REMOVED BY A DENTIST? ❑ YES ❑ NO

DID THE PATIENT EVER SUCK HIS/HER THUMB? ❑ YES ❑ NO IF YES, TO WHAT AGE?

DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS? ❑ LIP BITING ❑ PENCIL BITING ❑ FINGERNAIL BITING ❑ TONGUE BITING

❑ OTHER

HAS THE PATIENT HAD: ❑ SPEECH THERAPY ❑ TONGUE THRUST THERAPY

DOES THE PATIENT HAVE ANY PROBLEMS WITH SPEECH AT THE PRESENT TIME? ❑ YES ❑ NO

DOES THE PATIENT HAVE ANY DIFFICULTY IN CHEWING OR SWALLOWING FOOD? ❑ YES ❑ NO

DOES THE PATIENT HAVE FREQUENT HEADACHES? ❑ YES ❑ NO

DOES THE PATIENT HAVE ANY CLICKING OR PAIN IN THE JAW JOINTS WHEN OPENING OR CLOSING HIS/HER MOUTH? ❑ YES ❑ NO

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? ❑ YES ❑ NO

DOES THE PATIENT HAVE SENSITIVE TEETH OR GUMS? ❑ YES ❑ NO

DOES THE PATIENT'S GUMS BLEED EASILY WHILE BRUSHING HIS/HER TEETH? ❑ YES ❑ NO

HAS THE PATIENT HAD ANY PERIODONTAL TREATMENT? ❑ YES ❑ NO

_____ _____

SIGNATURE ***DATE***