Quad City Orthodontics

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. We look forward to meeting you.

Patient Information

Patient Name _____ Age _____
First Middle Last

Preferred Name _____ ☐ Male ☐ Female Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____

School (if under 18) _____ Grade ____ Favorite Hobbies _____

Whom may we thank for referring you? _____

e-mail (for appointment reminders) _____

Who is bringing you to your first appointment? _____

List the names of whom we may speak with in regards to treatment in the future? _____

_____

Whom should we contact for appointment reminders via text in the future? _____

☐ Yes ☐ No Have any other family members been treated in our office? If "yes", who? _____

_____

Responsible Party Information

(up to 26 years old)

Living with: ☐ Mother ☐ Father ☐ Both ☐ Other

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Father's Name _____
Step Mother's Name _____
Address _____
City _____ State _____ Zip _____
Birthdate _____
Home Phone _____
Cell Phone _____
Employer _____
Occupation _____
Work Phone _____

Mother's Name _____
Step Father's Name _____
Address _____
City _____ State _____ Zip _____
Birthdate _____
Home Phone _____
Cell Phone _____
Employer _____
Occupation _____
Work Phone _____

Orthodontic Insurance Information

Primary

Policy Holder's Name _____ Birthdate _____

Relationship to Patient _____ SS or ID# _____

Employer _____

Insurance Company _____ Insurance Company Phone _____

Insurance Company Address _____

Secondary

Policy Holder's Name _____ Birthdate _____

Relationship to Patient _____ SS# or ID# _____

Employer _____

Insurance Company _____ Insurance Company Phone _____

Insurance Company Address _____

Medical and Dental History

Medical

Physician _____ **Phone #** _____

List any medications currently taken: _____

☐ Yes ☐ No **Is the patient under the care of a physician?**
If "yes", for what condition? _____

☐ Yes ☐ No **Any changes in general health within the last year?**
☐ Yes ☐ No **Any sensitivities or allergies? If "yes", please list:** _____
☐ Yes ☐ No **Have bisphosphonates or bone density medications ever been taken? (ie., Boniva or Fosomax)**
☐ Yes ☐ No **Have tonsils or adenoids been removed?**
☐ Yes ☐ No **Are frequent headaches present?**
☐ Yes ☐ No **Has a physician or dentist recommended that an antibiotic be taken before dental treatment?**

Has the patient been treated for any of the following in the past year? (circle below any that apply)
Arthritis Asthma Blood Disorder Cancer Connective Tissue Disorders Diabetes Epilepsy
Heart Condition Kidney Disorder Nervous Disorder Tuberculosis

Dental

Primary Dentist _____ **Phone #** _____

Date of last dental visit? _____

☐ Yes ☐ No **Has the patient ever seen an orthodontist? If "yes", when?** _____
☐ Yes ☐ No **Any missing or extra teeth?**
☐ Yes ☐ No **Any injuries to the face, mouth or chin?**
☐ Yes ☐ No **Any primary (baby) or permanent teeth removed by the dentist?**
☐ Yes ☐ No **Pain/tenderness in the jaw joint (TMJ/TMD)?**
☐ Yes ☐ No **Musical instrument with a mouthpiece? If "yes", which one?** _____
☐ Yes ☐ No **Are there other dental issues not listed that you would like to discuss or have treated?**
If "yes", please explain _____

Has the patient had any of the following habits or dental conditions in the past year? (circle below any that apply)
Grinding Teeth Finger/Thumb Sucking Tongue Thrusting Mouth Breathing Speech Problems
Chewing/Eating Problems Gingivitis/Periodontal Disease

Your "Smile" Questionnaire

What changes would you like to see? _____

Are you concerned with any of the following? (please check all that apply)

☐ Yes ☐ No **Teeth that are crooked or crowded?**
☐ Yes ☐ No **Spaces between teeth?**
☐ Yes ☐ No **Front teeth "sticking out" too much?**
☐ Yes ☐ No **Too much or too little gum tissue showing when smiling?**
☐ Yes ☐ No **An overbite or underbite?**
☐ Yes ☐ No **Profile or facial appearance?**

Signature

I understand that the information that I have provided is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical status. I authorize Quad City Orthodontics to release necessary information including diagnosis and/or diagnostic records to third party payers or practitioners.

I consent to examination by the doctor to determine details of malocclusion.

_____ _____
Signature (If under 18, have responsible adult person sign) **Date**