SHINEY SMILES
Orthodontics

Patient Information

Today's Date _____

Patient's Name _____ **Nick name** _____

Address _____ **City** _____ **Zip** _____

Email Address_____ **Home Phone** _____**Cell Phone** _____

SSN _____ **DOB** _____/_____/_____ **Age** _____ **Sex** _____

School _____ **Grade** _____ **Hobbies/Interests** _____

General/Pediatric Dentist _____ **City**_____**Last Visit** _____

Whom may we thank for referring you to our office? _____

Siblings: Name/Age _____

Responsible Party Information

Father's Name _____ ❑ Biological ❑ Other _____

Address _____**City**_____ **How Long?** _____

Home Phone _____**Work Phone** _____**Cell Phone** _____

Social Security Number _____ - ____ - _____ **DOB** _____/_____/_____ **Email** _____

Employer _____**Occupation** _____ **How Long?** _____

Mother's Name_____❑ **Biological** ❑ **Other** _____

Address _____**City**_____ **How Long?** _____

Home Phone _____**Work Phone**_____ **Cell Phone** _____

Social Security Number _____ - ____ - _____ **DOB** _____/_____/____ **Email** _____

Employer _____**Occupation** _____ **How Long?** _____

Person financially responsible for this account _____

Orthodontic Insurance Information

Primary Dental Insurance **Orthodontic Coverage** ❑ Yes ❑ No

Insured's Name _____ **Relation** _____ **Employer** _____

DOB _____/_____/_____ **SSN** _____

Insurance Company _____ **Group No.** _____ **Insurance IDN** _____

Insurance Company Address _____ **City** _____ **Zip** _____

Do you have dual coverage? ❑ Yes No

Secondary Dental Insurance **Orthodontic Coverage** Yes ❑ No

Insured's Name _____ **Relation:** _____ Employer: _____

DOB _____/_____/_____ **SSN** _____

Insurance Company _____ **Group No**. _____ **Insurance IDN** _____

Insurance Company Address _____ **City** _____ **Zip** _____

Insurance Company Phone _____

Emergency Information

Contact Person _____ **Relation** _____ **Phone** _____

Medical History

Physician's Name_____ Last Visit _____ Phone Number _____

Current physical condition ❑ Good ❑ Fair Poor Currently under the care of a physician? ❑ Yes ❑ No

Ever been under the care of a physician for a major illness? ❑ Yes ❑ No _____

Please answer all questions by checking 'Yes' or 'No".

Good Health	❑ Yes ❑ No	Bleeding disorder	❑ Yes ❑ No
Recent illness	❑ Yes ❑ No	Prolonged bleeding	❑ Yes ❑ No
Recent cold, cough	❑ Yes ❑ No	Leukemia	❑ Yes ❑ No
Heart or chest pain	❑ Yes ❑ No	Sickle cell anemia	❑ Yes ❑ No
Heart murmur	❑ Yes ❑ No	Anemia	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Joint replacement	❑ Yes ❑ No
Rheumatic fever	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Kidney disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Lung disease	❑ Yes ❑ No	Sinus problems	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Hay fever, seasonal allergies	❑ Yes ❑ No
Hepatitis	❑ Yes ❑ No	Nasal obstruction	❑ Yes ❑ No
Herpes (cold sores)	❑ Yes ❑ No	Severe headaches	❑ Yes ❑ No
AIDS or HIV positive	❑ Yes ❑ No	Bone disorder	❑ Yes ❑ No
Endocrine disorder	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Growth disorder	❑ Yes ❑ No	Canker Sores	❑ Yes ❑ No
Tonsils/Adenoids removed	❑ Yes ❑ No	Antibiotics required for	
Still Growing	❑ Yes ❑ No	Dental appointments	❑ Yes ❑ No

List any drugs (prescription and over the counter) that currently taking and please give reason _____

_____

List any allergies or sensitivities _____

Including drug, latex metal or other _____

Has patient reached puberty? ❑ Girl – Started Menstruation ❑ Yes ❑ No _____

❑ Boy – Voice Changed/Facial hair ❑ Yes ❑ No _____

Dental History

What is the main concern you would like orthodontics to accomplish? _____
_____

Current Dental Health ❑ Good ❑ Fair ❑ Poor
Has an orthodontist been consulted previously? ❑ Yes ❑ No Have you ever been treated with orthodontics before? ❑ Yes ❑ No If yes, please explain: _____
Family history of orthodontic treatment ❑ Yes ❑ No_____
Has the patient ever sucked a thumb or finger? ❑ Yes ❑ No If yes, until what age? ____
Has your child ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No
Does your child have a tongue thrust? ❑ Yes ❑ No Any history of speech problems? ❑ Yes ❑ No
Has your child ever had injuries to your face, mouth, teeth or chin? ❑ Yes ❑ No
Does your child generally breath through their mouth? Awake: ❑ Yes ❑ No Asleep ❑ Yes ❑ No
Does your child have any missing or extra permanent teeth? ❑ Yes ❑ No _____

I have read and understand the above questions. I will not hold Dr. Newman or and member of his staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature_____**Date** _____