

BILLY POWELL ORTHODONTICS

Patient Information

Today's Date _____

Patient's Full Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____

Date of Birth _____

Age _____

Sex:

Male

Female

School Attending _____

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

Dentist _____

Dental Group _____

Address _____

Phone # _____

Responsible Party Information

Name or guardian's name child lives with _____

Relationship to patient _____

Responsible party full name _____

Resident Address _____

City _____ State _____ Zip _____

Mailing Address (if different) _____

Home Phone _____

Cell Phone _____

Mom _____ Dad _____

Father's Name _____

Social Security # _____

Date of Birth _____

Employer _____ Work # _____

Email Address _____

Mother's Name _____

Social Security # _____

Date of Birth _____

Employer _____ Work # _____

Email Address _____

Please Turn Over For More Information

**Insurance Information
Primary**

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Secondary

Dental Insurance Name _____
Insured Person _____
Social Security # _____ DOB _____
Employer _____
Insurance Address _____
City _____ State _____ Zip _____
Insurance Phone # _____ Group # _____

Health Questionnaire

Name of Physician _____
Date of last exam _____

Do you have or use any of the following (indicate with an "x"):

- | | |
|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets, or pressure | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Food Impaction | <input type="checkbox"/> Clenching or grinding teeth |
| <input type="checkbox"/> Burning of Tongue | <input type="checkbox"/> Swelling or lumps in mouth |
| <input type="checkbox"/> Frequent blisters on lips or mouth | <input type="checkbox"/> Pain around ear |
| <input type="checkbox"/> Unusual sounds in ear while eating | <input type="checkbox"/> Bad Breath |
| <input type="checkbox"/> Unpleasant taste | <input type="checkbox"/> Unfavorable dental experience |
| <input type="checkbox"/> Complications from extractions | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Mouth breathing |
| <input type="checkbox"/> Oral habits (fingernail biting, cheek biting) | <input type="checkbox"/> Cigarettes, pipe or cigar smoking |
| <input type="checkbox"/> Frequency of brushing _____ x a day | <input type="checkbox"/> Dental Floss |
| <input type="checkbox"/> Water jet device | <input type="checkbox"/> Fluoride supplements |

Medical History

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies to drugs | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Any heart ailments | <input type="checkbox"/> Neurological disorders | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Anemia/blood problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever/allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Liver problems/hepatitis | <input type="checkbox"/> Malignancies |
| <input type="checkbox"/> Psychiatric/emotional care | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Immune System Disorders (HIV, AIDS) |
| <input type="checkbox"/> Eye Disorders | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcer or colitis | <input type="checkbox"/> Pregnancy, if so, what month _____ |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Injuries to the mouth/jaw | <input type="checkbox"/> Recurrent headaches, if so, location
_____ Front _____ Back of head _____ Side |

Describe any current medical treatment including drugs taking, including those not listed above:

Signature of responsible party _____ Date _____