OptimalOrthodontics

SCOT E. BURGESS, DMD, PC

Please answer all questions on **both sides** of this form so that we may diagnose your oral health or your child's as accurately as possible. All information will be kept strictly confidential. Thank you.

Patient Name _____ Male or Female

Birthdate _____/_____/_____ Age _____ Married Single Divorced

Mailing Address _____ City, State & Zip Code _____

Home Phone # _____ Cell Phone#_____ Email_____

Employer _____ / Phone #_____ SSN (If Adult)_____

Responsible Party (If other than patient)

Mother (or Spouse)_____ Birthdate____/____/_____ SSN_____

Home Phone _____ Cell Phone_____ Email_____

Mailing Address_____ City, State & Zip Code_____

Employer_____ / Phone #_____

Father (or Spouse) _____ Birthdate____/____/_____ SSN_____

Home Phone _____ Cell Phone_____ Email_____

Mailing Address_____ City, State & Zip Code_____

Employer_____ / Phone #_____

With whom does the child reside _____

Emergency Contact

Name: _____ Phone # _____ Relationship to Patient: _____

Names of other family members seen by us_____

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

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insured _____	Insured _____
Employer _____	Employer_____
INSURANCE CO._____	INSURANCE CO._____
ID# _____ GROUP# _____	ID# _____ GROUP#_____
Birthdate _____/_____/_____	Birthdate _____/_____/_____
SSN _____	SSN_____
Relationship to Patient_____	Relationship to Patient_____

Dental/Medical History

General Dentist's Name: _____Date of last visit: _____

Have any teeth been extracted? If so why?_____ _____

Have you had previous orthodontic treatment or consultation? If so When? _____

Family Physician's Name: _____Date of last visit: _____

Please circle any of the following which you or the patient has or has had in the past

High/Low Blood Pressure	**Y N**	Heart Murmur/Rheumatic Fever	**Y N**
Diabetes	**Y N**	Blood /Transfusion/Anemia / Disease	**Y N**
Hepatitis / Liver Disease	**Y N**	Bleeding Disorder/Prolonged Bleeding	**Y N**
Thyroid/Parathyroid Disease	**Y N**	Cough/Tuberculosis (TB) / Lung Disease	**Y N**
Psychiatric Treatment	**Y N**	Mononucleosis or Epstein-Barr virus	**Y N**
Chemotherapy/Cancer	**Y N**	Arthritis/Rheumatism	**Y N**
Venereal Disease	**Y N**	Epilepsy/Seizures/Convulsions	**Y N**
Fainting/Dizzy spells/Convulsions	**Y N**	Mouth Breather	**Y N**
Drug/Alcohol Addiction	**Y N**		

Other serious medical condition(s) please list:

Have you had any surgeries or prosthetic implants (eg. Hip, heart valve or knee, etc..)? If yes, please explain

Please circle any allergy or adverse reaction to any of the following you or the patient has experienced

Penicillin Latex Metals Jewelry Dental anesthesia other

Has the patient experienced any of the following?

Had an unpleasant dental experience?	**Y N**	Nervousness regarding orthodontic treatment?	**Y N**
Pre-medicated for dental work?	**Y N**	Sucked thumb or fingers?	**Y N**
Required speech therapy?	**Y N**	Clench or grind teeth?	**Y N**
Experience cheek or temple pain?	**Y N**	Experience frequent headaches?	**Y N**
Experience neck or shoulder pain?	**Y N**	Treatment for Periodontal/Gum disease?	**Y N**
Does the jaw click or pop?	**Y N**	Does the jaw ever get stuck open?	**Y N**
Does it hurt to chew?	**Y N**	Is there pain in front of the ears?	**Y N**

Has the patient had any injuries to the face, teeth or jaws? If so please explain.

Does the patient play a musical instrument? If so what type?

Is the patient currently taking medications? If yes, please list.

Has the patient been under the care of a medical doctor during the past two years for a chronic condition?

Has the patient had or has any serious medical condition(s)?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my or my child's medical status.

Parent/Guardian Signature_____ Date___/_____/_____