JUDD ORTHODONTICS

New Patient Information

Date _____

Patient's Name _____ Nickname_____

Address _____

City _____ ST_____ ZIP_____

Email _____

Birth Date _____/_____/_____ Age _____

Sex: Male Female

Cell Phone _____ Home Phone _____

School _____ Grade _____

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

General Dentist _____ City _____

Father's Name _____ Mother's Name _____

Responsible Party Information

Name (if different from above) _____

Address _____ City _____ ST_____ ZIP_____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security Number _____-_____-_____ Birth Date _____/_____/_____ Relationship to Patient _____

Employer _____

Occupation _____ No. Years Employed _____

Person financially responsible for this account Self Father Mother Other_____

Marital Status Single Married Divorced

Name of nearest relative not living with you _____ Phone _____

Orthodontic Insurance Information

Insured's Name _____ Birth Date _____/_____/_____ SSN _____-_____-_____

Insurance Company _____ Group No. _____

Employer _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes No

2nd Insured's Name _____ Birth Date _____/_____/_____ SSN _____-_____-_____

Insurance Company _____ Group No. _____

Employer _____

Insurance Co. Address _____ Phone _____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

Signature _____ **Date** _____

Health History

Are you presently under the care of a physician? Yes No

If yes, for what conditions: _____

_____

Name of Physician: _____ Phone: ( ) _____

In the last five years, have you ever been:

Hospitalized	Yes	No
Had a serious illness	Yes	No
Had a major operation	Yes	No

Have you ever had, or do you presently have any of the following conditions?

Heart Surgery, Heart Disease, or Heart Attack	Yes	No	Thyroid Disease	Yes	No
Angina Pectoris/Chest Pain	Yes	No	Ulcer	Yes	No
High/Low Blood Pressure	Yes	No	AIDS or HIV positive	Yes	No
Heart Murmur	Yes	No	Hepatitis, Jaundice, or Liver Disease	Yes	No
Rheumatic Fever/Rheumatic Heart Disease	Yes	No	Blood Transfusion	Yes	No
Congenital Heart Lesions/Mitral Value Prolapse	Yes	No	Drug Addiction/Alcoholism	Yes	No
Artificial Heart Valve / Heart Pacemaker	Yes	No	Hemophilia or Excessive Bleeding	Yes	No
Use of Bisphosphonates or treatment for osteoporosis	Yes	No	Use of Fen-Phen, Redux, or diet pills	Yes	No
Artificial Joint/Prosthesis	Yes	No	Use of Coumadin or blood thinners	Yes	No
Stroke	Yes	No	Organ Transplant	Yes	No
Kidney Disease	Yes	No	Psychiatric Treatment	Yes	No
Cancer or Tumors	Yes	No	Allergies/Hay Fever	Yes	No
Radiation Treatment of the Head or Neck	Yes	No	Asthma	Yes	No
Lung Disease/Tuberculosis	Yes	No	Sinus Trouble	Yes	No
Diabetes	Yes	No	Seizures/Epilepsy	Yes	No
Jaw Joint (TMJ) Problems	Yes	No	Arthritis	Yes	No

Have you ever had an allergic or unusual reaction to any of the following?

Latex Materials	Yes	No
Erythromycin or Other Antibiotics	Yes	No
Sulfa Drugs	Yes	No
Any Other Medication or Drugs	Yes	No

Which Ones? _____

Women: Are you pregnant? Yes No If Yes, How Many Months? _____

Are you taking Birth Control Pills? Yes No

If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication. Therefore, if you are prescribed antibiotics during orthodontic treatment, additional birth control methods should be used until your next menses.

Please list any medication (over the counter or prescription) that you are now taking:

_____

_____

_____

If you have ever had any serious complications involving dental treatment, please explain:

_____

_____

_____

Dental History

Family Dentist: _____

Date of your last visit to this dentist: _____

How many times per day do you ***BRUSH*** your teeth? 0 1 2 3+

How many times per day do you ***FLOSS*** your teeth? 0 1 2+

History of:			Specifics of Problem if ***Yes:***	Please explain all ***Yes*** answers:
Tooth Injury	Yes	No	Chipped / Broken / Lost	_____
Jaw Injury	Yes	No	At Age: _____	_____
Oral Disease	Yes	No	Ulcers / Sores	_____
Jaw Joint Pain	Yes	No	Right: Constant / Periodic	_____
			Left: Constant / Periodic	_____
Jaw Joint Noises	Yes	No	Right: Click / Pop / Grating	_____
			Left: Click / Pop / Grating	_____
Jaw Joint Locking	Yes	No	Right: When Open / Closed	_____
			Left: When Open / Closed	_____
Grinding Your Teeth	Yes	No	During Day / When Sleeping	_____
Clenching Your Teeth	Yes	No	During Day / When Sleeping	_____
Bleeding Gums	Yes	No	Brushing / Flossing / Eating	_____
Oral Habits	Yes	No	Thumb Sucking / Finger Sucking / Tongue Thrusting / Nail Biting	
				_____
Other Oral Problems	Yes	No	_____	
			_____	

Have you ever had:			What kind of treatment?	Doctor seen:
Periodontal (gums) Treatment	Yes	No	_____	_____
Orthodontic (braces) Treatment	Yes	No	_____	_____
Endodontic (root canal) Treatment	Yes	No	_____	_____
Oral Surgery (jaw surgery) Treatment	Yes	No	_____	_____
Prosthodontic (crown & bridge) Treatment	Yes	No	_____	_____

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time and that I have also received a copy of this office's Notice of Privacy Practices. If there are any future changes in this information, I will inform this practice of these changes. I understand that credit bureau reports may be obtained for financial purposes (your credit will not be affected).

_____

Patient Signature (or Guardian) Date

_____

Doctor Signature Date of review

_____

Treatment Coordinator Signature Date of review