KAPLAN ORTHODONTICS

ORTHODONTIC PATIENT INFORMATION FORM

Patient Information

Date Form Completed _____

Name: _____
First Middle Initial Last Preferred Name

Date of Birth: _____ Gender: ☐M ☐F SSN: _____

Address: _____
Street City State Zip Code

Phone: _____ _____ _____
Home Mobile Mobile Carrier

Email Address: _____ Occupation: _____

Employer: _____

Marital Status: ☐Single ☐Separated ☐Divorced ☐Married Spouse Name: _____

Insurance Information

Do you have Dental/Orthodontic Insurance? _____ Do you have Secondary Insurance? _____

Insurance Company Name: _____ Insurance Company Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Group/Plan #: _____ Group/Plan #: _____

Name of Primary Insured: _____ Name of Primary Insured: _____

Birthdate: _____ Birthdate: _____

SSN/ID # _____ SSN/ID # _____

Note: If you would like us to determine your orthodontic benefits and subsequently bill your insurance as a courtesy for any treatment rendered, insurance information must be filled out completely.

Responsible Party Information

Responsible Party? ☐Self (Same As Above) ☐Other (Please provide additional information below)

Name: _____ Relation: _____
First Middle Initial Last

Date of Birth: _____ SSN/ID # _____

Address: _____
Street City State Zip Code

Phone: _____ _____ _____
Home Mobile Mobile Carrier

Email Address: _____ Occupation: _____

Employer: _____

Marital Status: ☐Single ☐Separated ☐Divorced ☐Married Spouse Name: _____

Note: Please list the person(s) responsible for this account. If the responsible party is other than the patient, that person is responsible for signing all financial contracts.

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ORTHODONTIC PATIENT HEALTH QUESTIONNAIRE

I. Subjective Concerns

A. What are the patient's or parent's main concerns regarding the jaw and teeth?

- ☐ Dentist Recommended Seeing an Orthodontist
- ☐ Crowding of Upper Teeth
- ☐ Crowding of Lower Teeth
- ☐ "Buck" Teeth/Overjet
- ☐ Overbite
- ☐ Underbite
- ☐ Spaces
- ☐ Bad Bite
- ☐ Crossbite
- ☐ Grinding Teeth
- ☐ Gummy Smile
- ☐ Impacted Tooth/Teeth
- ☐ Improper Tooth Position
- ☐ Irregular Facial Proportions
- ☐ Irregular Shaped Tooth/Teeth
- ☐ Missing Tooth/Teeth
- ☐ Mouth Too Small
- ☐ Open Bite
- ☐ Prominent Lower Jaw (too "strong")
- ☐ Protrusion of Teeth
- ☐ Recessive Lower Jaw (too "weak")
- ☐ Rotations
- ☐ Small Teeth
- ☐ Thumb/Finger Habit
- ☐ Other _____

B. Family Members with similar problems

- ☐ Father
- ☐ Mother
- ☐ Brother
- ☐ Sister
- ☐ Other _____

C. Has the patient ever had a history with any of the following?

- ☐ Difficulty Chewing
- ☐ Difficulty Swallowing
- ☐ Finger/Thumb Sucking
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Lip Biting
- ☐ Mouth Breathing
- ☐ Pain in jaw joint
- ☐ Snoring
- ☐ Speech Problems
- ☐ Tongue Thrusting
- ☐ Tonsillitis

II. Medical History

A. Medications (current medications taken by the patient):

_____

_____

B. Allergies:

- ☐ Jewelry/Metals
- ☐ Latex
- ☐ Aspirin
- ☐ Codeine
- ☐ Antibiotics _____
- ☐ Other _____

C. Has the patient ever had any of the following?

- ☐ Allergies
- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Disease
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Endocrine Problems
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hospitalized
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Ringing of Ears
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Thyroid Problems
- ☐ Trauma
- ☐ Ulcers

D. Are there any medical, dental, surgical or psychological problems not covered above?

_____

_____

III. Patient's or Parent's attitude toward dental care and orthodontic treatment.

Patient's General Dentist _____

Town, State _____

Last visit for cleaning/exam _____

Any work still needing to be completed? ☐ Yes ☐ No

A. Regular dental checkups:

- ☐ Twice a year
- ☐ Only if necessary
- ☐ Once a year
- ☐ None

B. Patient's attitude towards orthodontic treatment:

_____

_____

C. Has the patient ever had any unusual dental experiences?

D. Has the patient ever had a previous orthodontic consultation/treatment? If yes, Name of Doctor.

E. Why are you seeking this consultation?

To the best of my knowledge, all the proceeding answers are true and correct. If deemed advisable, I grant permission for my physician to be contacted for information and advice. If I have any change in my health or medications that are not reported above, I will inform the doctor at my next visit.

Patient/Responsible Party's Signature

Date