ORTHODONTIC ASSOCIATES OF MERCER ISLAND
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PATIENT INFORMATION

First: _____ Middle Initial: _____ Last: _____ Nickname: _____

Birthdate: _____ Gender: _____ Email: _____

Phone: _____ Cell/Alternate Phone: _____

Address: _____ City/State: _____ Zip: _____

List friends or relatives in the practice: _____

How did you find out about our office? _____

List any sports, hobbies, or musical instruments played: _____

FINANCIAL PARTY INFORMATION (IF INFORMATION IS DIFFERENT THAN PATIENT)

First: _____ Last: _____

Phone: _____ Cell/Alternate Phone: _____

Email: _____

Address: _____ City/State: _____ Zip: _____

Relationship to Patient: _____ Occupation: _____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS UNDER 18)

Parent/Guardian Name: _____

Parent/Guardian Name: _____

☐ Married ☐ Single ☐ Separated ☐ Divorced If separated or divorced, which parent does child live with? _____

Please list the name and birthdate of any siblings: _____

_____

DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ City/State: _____ Phone: _____

Subscriber's Name: _____ Subscriber's #/SS: _____ Birthdate: _____

Subscriber's Employer: _____ Group #: _____ Phone: _____

DENTAL HISTORY

Patient's Dentist: _____ Phone: _____ Last Cleaning: _____

Please describe your orthodontic concern: _____

Has the patient had any previous orthodontic treatment? With whom? _____

What concerns you most about the thought of orthodontic treatment? _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Speech problems/therapy?	☐ YES ☐ NO	Floss teeth daily?	☐ YES ☐ NO
Grind or clench teeth?	☐ YES ☐ NO	Flouride treatments?	☐ YES ☐ NO
Oral habits (thumb/finger sucking, lip/nail biting)?	☐ YES ☐ NO	Mouth breathing?	☐ YES ☐ NO
Injury to face, jaw, teeth, or mouth?	☐ YES ☐ NO	Snores during sleep?	☐ YES ☐ NO
Discomfort from teeth or gums?	☐ YES ☐ NO	Any missing or extra permanent teeth?	☐ YES ☐ NO
Pain, tenderness, or noise in either jaw?	☐ YES ☐ NO	Apprehensive about dental care?	☐ YES ☐ NO
Frequent sore throats?	☐ YES ☐ NO	Frequently chews gum?	☐ YES ☐ NO
Requires premedication?	☐ YES ☐ NO	Ringing in the ears?	☐ YES ☐ NO
Brush teeth daily?	☐ YES ☐ NO		

If you answered YES to any of the questions above, please explain: _____

_____

_____

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MEDICAL HISTORY

Patient's Physician: _____ Address: _____

Phone: _____ Is patient in good health? ☐ YES ☐ NO Date of last physical: _____

Please list any medications currently being taken by patient: _____

_____

_____

Have you taken any Bisphosphonates? ☐ YES ☐ NO If YES, when? _____

Please list any drug allergies/sensitivities patient may have: _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Rheumatic Fever	☐ YES ☐ NO	Cancer	☐ YES ☐ NO
Tuberculosis/Lung Disease	☐ YES ☐ NO	Family History of Cancer	☐ YES ☐ NO
Pneumonia	☐ YES ☐ NO	Received Radiation Therapy	☐ YES ☐ NO
Liver Disease	☐ YES ☐ NO	Growth Problems	☐ YES ☐ NO
Kidney Disease	☐ YES ☐ NO	Endocrine Problems	☐ YES ☐ NO
Heart Attack/Stroke	☐ YES ☐ NO	Hormone Therapy	☐ YES ☐ NO
Heart Disease	☐ YES ☐ NO	Latex/Metal Allergy	☐ YES ☐ NO
Congenital Heart Defect	☐ YES ☐ NO	Nervous Disorders	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	Bone Disorders/Bone Loss	☐ YES ☐ NO
Hemophilia	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO
Hypertension/High Blood Pressure	☐ YES ☐ NO	Seizures/Epilepsy	☐ YES ☐ NO
Prolonged Bleeding/Transfusion	☐ YES ☐ NO	Handicaps/Disabilities	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Asthma	☐ YES ☐ NO
HIV/AIDS	☐ YES ☐ NO	Arthritis	☐ YES ☐ NO
Hepatitis	☐ YES ☐ NO	Treated for Emotional Problems	☐ YES ☐ NO
Tonsils/Adenoids Removed	☐ YES ☐ NO	Ever Been Hospitalized	☐ YES ☐ NO

If you answered YES to any of the questions above, please explain: _____

_____

_____

Sleep Apnea Questionnaire:

Do you have concerns regarding sleep apnea or have you been diagnosed with sleep apnea? ☐ YES ☐ NO

Do you have disrupted sleep? ☐ YES ☐ NO

Do you fall asleep during the day? ☐ YES ☐ NO

Do you have disrupted sleep? ☐ YES ☐ NO

Do you snore heavily or talk in your sleep? ☐ YES ☐ NO

Do you suffer from daytime sleepiness or fatigue? ☐ YES ☐ NO

For children, does your child wet the bed and/or have behavioral issues such as ADD/ADHD? ☐ YES ☐ NO

If the patient is under the age of 18, please answer the following questions:

Height: _____ Weight: _____ School: _____ Grade: _____

If patient is a girl, has menstruation began? ☐ YES ☐ NO If so, when? _____

If patient is a boy, has their voice changed? ☐ YES ☐ NO

Has the patient grown in the past year or has their shoe size changed recently? ☐ YES ☐ NO

Is patient interested in orthodontic treatment? ☐ YES ☐ NO

Has either biological parent ever had orthodontic treatment? ☐ YES ☐ NO

Signature: _____ Date: _____