PATIENT INFORMATION

Date:______________________

Patient: Mr. / Mrs. / Ms. / Dr. ____
(Circle One) (Last Name) (First Name) (Middle Initial)

Date of Birth: __________________________________ Age: __________________ years ______________ months
Mo. Day Yr.

Address: ____
(Street) (City) (Zip)

How long at this address? ___________________________ Home Phone: ________________________________

Email: _____________________________________ Cell: ____

Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced Social Security Number*: ___________________________
*For insurance purposes.

Is orthodontic insurance available? ( ) None ( ) Patient ( ) Spouse ( ) Other

Patient's Employer: ____________________________ How long: _____________ Occupation: ____________________
Business Address: ____ Business Phone: _____________________
Insurance Company: _____________________ I.D. Number: ____________________ Group Number: ______________

(Please Give Your Dental Insurance Card to the Receptionist to Copy For Your File)

Patient's Dentist: You were recommended to our office by: :

SPOUSE'S NAME: Mr. / Mrs. / Ms. / Dr. _______________________________________ Date of Birth: _________________
Social Security Number*: ___________________________ Cell: _____________________________
Email: ____
Employer: __________________________________ How long: __________ Occupation: _________________________
Business Address: ____ Business Phone: _______________________
Insurance Company: ___________________________I.D. Number: ________________ Group Number: _____________

(Please Give Your Dental Insurance Card to the Receptionist to Copy For Your File)

PERSON RESPONSIBLE FOR ACCOUNT

Check one: ( ) Patient ( ) Spouse ( ) Both ( ) Guardian ( ) Parent

AUTHORIZATION

I consent to the dentist's use and disclosure of my records to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. I acknowledge that I have had an opportunity to review the office privacy notice and I am in agreement with the office privacy practices.

I consent to the disclosure of my records, treatment information, appointments, etc. to the following persons who are involved in my care or payment for that care (i.e. spouse, parent, etc). My consent to disclosure of records shall be effective until I revoke it in writing.

______________________ ______________________ ______________________ ______________________
Print Name **Relationship to Patient** **Print Name** **Relationship to Patient**

I hereby authorize payment of the orthodontic insurance benefits to be made directly to Kittleson Orthodontics S.C. I understand that I am responsible for all costs of diagnosis and treatment not paid by the insurance company. I hereby authorize the orthodontic office to administer and perform such diagnostic and treatment procedures as may be necessary for proper orthodontic care. The information on this page and the medical history are correct to the best of my knowledge.

SIGNATURE OF PATIENT

X __________________________________ Print Name:____________________________ Date: __________________

KK-4A

HEALTH HISTORY and PATIENT INFORMATION

Your careful and completed answers to the following questions will be very helpful in the evaluation of your orthodontic problem.

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NAME: ____ **DATE:** ________________

Date of last medical examination: __________ Results: ____

Physician: ____________________ Address: ____

Height: _____________ Weight: ________________ Present health? Good ____ Fair ____ Poor ____

Do you have any history of a major illness? Yes ____ No ____

Have you been under the care of a physician during the past two years other than for routine examination? Yes ____ No ____

Check any of the following for which you have been treated:

Diabetes	___	Heart problems	___	Bone disorders	___
Hepatitis	___	Bleeding disorders	___	Joint pain	___
Anemia	___	Ear infections	___	Headaches	___
Aids / HIV	___	Hormone disorders	___	Convulsions	___
Allergies	___	Asthma / Hay fever	___	Arthritis	___
Cancer	___	Stomach disorders	___	Tuberculosis	___

If you answered yes to any of the questions, please explain:____
____
____

Do you vomit, gag, or faint easily? Yes ____ No ____

Do you have a tendency for colds? _____ sore throats? ____ ear infections? ____ Yes ____ No ____

Have you had your tonsils and adenoids removed ? What age _______ Yes ____ No ____

List any allergies or drug sensitivity: ____
____

Present drugs or medication being taken: ____

Do you have arthritis or pain in any joints of your body? Yes ____ No ____

Have you ever been treated for mental stress, nerves or an emotional problem? Yes ____ No ____

How many times a week do you have a headache? None ____ Few ____ Many ____

How many times a week do you take aspirin, Tylenol, or other pain medication? None ____ Few ____ Many ____

Women: Are you pregnant at the present time? Yes ____ No ____

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Dental History:

Have you had any injury of any type to your face, teeth, chin, or jaws? Yes ____ No ____

Give details of any injury:____
____

Have you ever been involved in an automobile, bike, swimming pool or any other sporting accident? Yes ____ No ____

Give details of any injuries:____

Have you ever had any pain in your jaw joints? Yes ____ No ____

Have you ever had any clicking or popping sounds from your jaw joints? Yes ____ No ____

Have you ever had a time when your jaw couldn't open of close? Yes ____ No ____

Have you ever had any muscle pain, tiredness or stiffness of the jaw or neck? Yes ____ No ____

Do you grind your teeth? While awake? ____ While asleep? ____ Yes ____ No ____

Do you have any speech problems? Yes ____ No ____

Have you experienced any problems with sore or bleeding gums? Yes ____ No ____

Are there any parts of your mouth or any teeth that are sore to pressure or irritants? (Cold, hot, sweets, biting hard foods, etc.) Yes ____ No ____

Have you ever had any unusual dental experiences? Yes ____ No ____

Specify: ____

(PLEASE COMPLETE THE OTHER SIDE)

The following are some habits of interest to the orthodontist. List information as it pertains to you.

Thumb sucking until age _____ years　Tongue thrusting　Yes ____ No ____
Finger sucking until age _____ Years　Mouth breathing　Yes ____ No ____
Lip-biting or sucking　Yes ____ No ____　Nail biting　Yes ____ No ____
Other habits　Yes ____ No ____　Explain: ________________________________

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PATIENT'S ATTITUDE TOWARD TEETH, FACE, AND ORTHODONTIC TREATMENT:

What are your main concerns regarding your jaws and teeth?

Crowding	___	Deep bite	___	"Buck" teeth	___	Receding chin	___
Spaces	___	Open bite	___	"Under" bite	___	Prominent chin	___
Neck pain	___	Gum disease	___	Clicking jaw	___	Headaches	___
Jaw pain	___	Gummy smile	___	Missing teeth	___	Face proportions	___

Others ____

Orthodontic consultation prompted by:
Dentist ____　Patient _____　Spouse ____　Friend ____
Physician ____　Mother _____　Father ____　Sibling ____
Other: (Specify) ___________________________
Patient's interest in orthodontic treatment:
Wants treatment: ____　Treatment if necessary ____　Unwilling but agree ____
Do you brush your teeth?
Several times a day ____　Nearly every day ____　Rarely ____
Once a day ____　Occasionally ____　Never ____
Do you have dental check-ups?
Twice a year ____　Once a year ____　Only if urgent ____　Never ____
When did you have your last dental check-up? ______________ By whom? ______________ Next visit? ________
Have you ever been placed on an oral hygiene program by the dentist?　Yes ____ No ____
Have you ever had any permanent teeth removed?　Yes ____ No ____
Are there any other family members with a similar orthodontic condition?　Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____
Has anyone in the family had orthodontic treatment?　Yes ____ No ____
Mother ____ Father ____ Sister ____ Brother ____
Have you had any previous orthodontic consultation, and / or treatment?　Yes ____ No ____
When? _______________ By whom? _________________________
What are your favorite hobbies, sports or pastimes? ____
____
By what name do you prefer to be called? _____________________________________
Are you aware that appointments will infringe on work time?　Yes ____ No ____
Are there any medical, dental or surgical problems not covered above?
(Specify) ____　Yes ____ No ____
Do you wish to talk to us privately about any special problem?　Yes ____ No ____

Thank you for your cooperation.

Signature of individual completing this form: ____________________________________

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MEDICAL UPDATES:

I have read the MEDICAL HISTORY dated ___________ and confirm that it adequately states past and present conditions.

Dates	Exceptions		Signature
_______	____	None [ ]	________________
_______	____	None [ ]	________________
_______	____	None [ ]	________________
_______	____	None [[	________________

Reviewed by: ______________________________　*Date:* ______________________

NAME: ________________________ DATE: _____________ NO: ________

PATIENT'S ATTITUDE TOWARD TEETH, FACE AND ORTHODONTIC TREATMENT

Please help us understanding your problem by checking the following information of what you would like orthodontic treatment to accomplish. Please be specific and circle the words that help you describe the requested changes (**more, less, forward, backward, longer, shorter, etc.**)

TEETH: If your teeth could be changed, how would you like them to change?

- ☐ straighten the front teeth **upper / lower**
- ☐ straighten the back teeth **upper / lower**
- ☐ make the upper front teeth **longer / shorter**
- ☐ move upper teeth **forward / backward**
- ☐ move lower teeth **forward / backward**
- ☐ make the line of the upper front teeth more level
- ☐ other ____

FACE: If your facial appearance could be changed, what would you change?

- ☐ get rid of sag under the lower jaw
- ☐ move chin **forward / backward**
- ☐ move chin **left / right** to center it
- ☐ move lower lip **forward / backward**
- ☐ move upper lip **forward / backward**
- ☐ move the area around my nose **forward / backward**
- ☐ make the profile of my nose **longer / shorter**
- ☐ move the area under my eyes **forward / backward**
- ☐ make my cheekbones **larger / smaller**
- ☐ show **more / less** of my **teeth / gums** when I smile
- ☐ make my lips **closer together / farther apart** when my teeth are touching
- ☐ make my lips not touch and roll out when my teeth are touching
- ☐ reduce the strain in my **chin / lips** when I close my lips
- ☐ make my face more **narrow / wide**
- ☐ reduce the **width / fullness** of my lower jaw behind my mouth
- ☐ other____

SYMPTOMS: If you want to reduce pain or discomfort where would it be located? Please be specific about the location; circle the right side, left side or both if they apply.

- ☐ in front of my ears **right / left**
- ☐ below my ears **right / left**
- ☐ above my ears **right / left**
- ☐ on my ears **right / left**
- ☐ neck **right / left**
- ☐ shoulders **right / left**
- ☐ temples **right / left**
- ☐ teeth
- ☐ sinuses
- ☐ eyes **right / left**
- ☐ other ____

KITTLESON ORTHODONTICS, S.C.