Westboro Orthodontic Associates

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Patient Information

Date _____

Patient's Name _____ Nickname _____

Address _____

Home Phone _____ Birth Date _____/_____/_____ Age _____ Sex _____

School _____ Grade _____

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

General Dentist _____ City _____

Family Physician _____ City_____

Siblings: Name _____ Age _____ Name _____ Age _____

Responsible Party Information

Father's Name _____

Address _____

Home Phone _____Work Phone _____

Email Address_____

Employer _____ Occupation _____No. Years Employed _____

Mother's Name _____

Address _____

Home Phone _____Work Phone _____

Employer _____ Occupation _____No. Years Employed _____

Person financially responsible for this account Father ☐ Mother ❑

Marital status single ❑ married ❑ divorced ❑ widowed ❑

Insurance Information

Insured's Name _____Birth Date _____/_____/_____ ID # _____

Insurance Company _____Group No. _____Local No. _____

Insurance Co Address _____ Phone _____

Do you have dual coverage? ❑ Yes ❑ No

2nd Insured's Name _____Birth Date _____/_____/_____ ID # _____

Insurance Company _____Group No. _____ Local No. _____

Insurance Co Address _____ Phone _____

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

Signature _____ **Date** _____

Medical History

Is patient in Good health? _____ ❑ Yes ❑ No

Does patient have a history of major illness? _____ ❑ Yes ❑ No

Has patient been under the care of a physician for a major illness? _____ ❑ Yes ❑ No

ASTHMA	❑ Yes ❑ No	CANCER	❑ Yes ❑ No	HIGH BLOOD PRESSURE	❑ Yes ❑ No
DIABETES	❑ Yes ❑ No	ANEMIA	❑ Yes ❑ No	PROLONGED BLEEDING	❑ Yes ❑ No
PNEUMONIA	❑ Yes ❑ No	EPILEPSY	❑ Yes ❑ No	FAINTING OR DIZZINESS	❑ Yes ❑ No
HEART TROUBLE	❑ Yes ❑ No	NERVOUS DISORDER	❑ Yes ❑ No	LIVER INVOLVEMENT	❑ Yes ❑ No
RHEUMATIC FEVER	❑ Yes ❑ No	TUBERCULOSIS	❑ Yes ❑ No	KIDNEY INVOLVEMENT	❑ Yes ❑ No
BONE DISORDERS	❑ Yes ❑ No	TMD SYMPTOMS	❑ Yes ❑ No	ENDOCRINE PROBLEMS	❑ Yes ❑ No
HEPATITIS	❑ Yes ❑ No	AIDS/HIV	❑ Yes ❑ No		

Have tonsils and adenoids been removed? What age? _____ ❑ Yes ❑ No

List any drugs or medications now being taken. Give reason:

_____

List any drug allergies or drug sensitivities: _____

Other allergies or sensitivities (e.g. latex, metals)_____

Has patient reached puberty? ❑ Girl – Started Menstruation _____ ❑ Yes ❑ No

❑ Boy – Voice Changed_____ ❑ Yes ❑ No

Dental History

Have there been injuries to the face, mouth, or teeth? _____ ❑ Yes ❑ No

Has the patient ever sucked a thumb or finger? Until what age? _____ ❑ Yes ❑ No

Does the patient have any speech problems? _____ ❑ Yes ❑ No

Have you been informed of any missing or extra permanent teeth? _____ ❑ Yes ❑ No

Has an orthodontist been consulted previously? _____ ❑ Yes ❑ No

Has either parent or patient had orthodontic treatment? _____ ❑ Yes ❑ No

What do you wish to gain from treatment?

_____

FOR OFFICE USE ONLY

	RT MOLAR	LT MOLAR
CLASS I		
CLASS II		
DIV II		
CLASS III		

RIGHT	LEFT
E D C B A	A B C D E
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
E D C B A	A B C D E

PANO _____
RECS _____
RECALL _____
FULL TX _____
PH I _____
LIMITED _____
TMD _____
_____
_____

OVERJET ❑ NORMAL ❑ EXCESSIVE _____MM ❑ EDGE TO EDGE

OVERBITE ❑ NORMAL ❑ OPEN _____% ❑ DEEP _____%

CROSSBITE ❑ RIGHT ❑ LEFT ❑ ANTERIOR

ARCH LENGTH UPPER ❑ MODERATE ❑ SEVERE

LOWER ❑ MODERATE ❑ SEVERE

MIDLINES UPPER ❑ RIGHT ❑ LEFT _____ MM _____

LOWER ❑ RIGHT ❑ LEFT _____ MM _____

PROFILE ❑ SATISFACTORY ❑ FLAT ❑ FULL ❑ CONCAVE

LIP POSTURE ❑ TOGETHER RELAXED ❑ TOGETHER STRAINED ❑ APART

TMD ❑ CLICKS ❑ PAIN ❑ RESTRICTIVE MOVEMENT ❑ TX PREVIOUSLY

HABITS ❑ TONGUE THRUST ❑ MOUTH BREATHER ❑ FINGER/THUMBSUCKING

ORAL HYGIENE ❑ EXCELLENT ❑ FAIR ❑ POOR

DATE	