

Sherri J. Reuland, D.D.S., M.S., P.A.

Specialist in Orthodontics
For Children and Adults

Patient's Name _____ Date ____ - ____ - ____
Address _____ City _____ State _____ Zip _____
Home Phone ____ - ____ Birthdate ____ - ____ - ____ Patient age ____ yr ____ mo
How did you hear about our office? _____
Name of General Dentist _____
Responsible Party's E-MAIL address - _____

Responsible Party Information

Responsible Party's Name _____ Spouse's Name _____
Mailing address _____ City _____ St. _____
How long at this address? _____ Home Ph. _____ Work Ph. _____
Birthdate ____ - ____ - ____ Relationship to Patient _____
Employer _____
Employer address _____ Occupation _____
Other Parent's Name (if different than spouse) _____
Mailing address _____ City _____ St. _____
Relationship to Patient _____ Home Ph. _____ Work Ph. _____
Birthdate ____ - ____ - ____ Employer _____
Employer address _____ Occupation _____

Insurance Information

Insured's name _____ Insured's SS# ____ - ____ - ____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insurance Co. Phone No. _____ Insured's Employer _____
Do you have dual coverage? Yes No If Yes:
Insured's name _____ Insured's SS# ____ - ____ - ____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Daytime Phone ____ - ____ - ____

Medical Information

Please indicate YES if you or the patient have ever had any of the following medical conditions

		For office use only
Heart Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mononucleosis? Yes <input type="checkbox"/> No <input type="checkbox"/>
Respiratory Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis? Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Polio? Yes <input type="checkbox"/> No <input type="checkbox"/>
Liver Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia? Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hemophilia? Yes <input type="checkbox"/> No <input type="checkbox"/>
Venereal Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Emphysema? Yes <input type="checkbox"/> No <input type="checkbox"/>
Intestinal Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Epilepsy? Yes <input type="checkbox"/> No <input type="checkbox"/>
Bone Disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Nervous/Emotional Problems? Yes <input type="checkbox"/> No <input type="checkbox"/>
Endocrine Problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	High or Low Blood Pressure? Yes <input type="checkbox"/> No <input type="checkbox"/>
HIV Positive?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Problems with Wound Healing? Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Transfusion?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic/Scarlet Fever? Yes <input type="checkbox"/> No <input type="checkbox"/>
Tumors or Cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatism or Arthritis? Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma or Hay Fever?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is Patient Under Medical Care? Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	History of Fainting or Dizziness? Yes <input type="checkbox"/> No <input type="checkbox"/>
Any Broken Bones?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the Patient have a drug addiction? Yes <input type="checkbox"/> No <input type="checkbox"/>
Prolonged Bleeding?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Patient Pregnant at this time? Yes <input type="checkbox"/> No <input type="checkbox"/>
Yellow Jaundice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Does the Patient Smoke? Yes <input type="checkbox"/> No <input type="checkbox"/>
Radiation Therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the Patient ever had Fever Blisters? Yes <input type="checkbox"/> No <input type="checkbox"/>
Chemical Therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Is the Patient in Good Health? Yes <input type="checkbox"/> No <input type="checkbox"/>

If female, Has Menstruation begun? Yes No

Is the Patient allergic to anything? Yes No

Please list all allergies _____

Is the Patient currently taking any medications? Yes No

Please list all medications _____

Are you aware of any other disease, condition, or problem not listed above that we should know about? Yes No

Please List _____

Dental History

		For office use only
Has the Patient Seen a General Dentist in the Last Year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Any Pain, Clicking or Discomfort in or Near the Ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Has the Mouth, Face or teeth been Injured by a Fall or Accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Have You been Informed of Missing or Extra Permanent Teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Are You Aware of Any "Gum" Problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Has a Physician or Dentist Advised Antibiotics Before a Dental Exam?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Have the Patient's Tonsils or Adenoids Been Removed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Do You Feel the Patient Can Benefit From Orthodontic Treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Is the Patient Happy with Their "Smile"?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Does the Patient Want to Improve Their "Smile" and "Bite"?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Would the Patient Mind Wearing "Braces"?	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Does the Patient Have or Ever Had Any of the Following Habits?

Cheek, Tongue, or Lip Chewing? Yes No

Finger Nail Biting? Yes No

Thumb Sucking? Yes No

Mouth Breathing? Yes No

Clenching Teeth? Yes No

Tongue Thrusting? Yes No

Grinding teeth? Yes No

Speech Problems? Yes No

I understand the information given is correct and will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

Patient Signature

Date

Parent Signature