

Patient Acquaintance and Health History

Janis P. Preston, D.D.S.

Diplomate of the American Board of Orthodontics

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_Date of Birth\_\_\_/\_\_\_/\_\_\_\_Gender: \_\_\_\_\_\_\_\_

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NICKNAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If Adult: Married Single Divorced Widow



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Residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street City/State/Zip

Home Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If applicable, what school does the patient attend? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN/RESPONSIBLE PARTY (if different from above)**

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Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

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Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: M S D W



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Residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL PARENT/GUARDIAN INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_/\_\_\_\_/\_\_\_\_

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Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: M S D W

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Residence\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I.D. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SS#\_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Policy Holder’s Date of Birth\_\_\_/\_\_\_/\_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I.D. #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Gender\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s SS# \_\_\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_ Policy Holder’s Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

I certify that the above information is complete, accurate and current. I authorize the release of any medical information necessary to properly submit to my insurance company and request payment of benefits to Preston Orthodontics, PLLC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

I authorize the release of any photographs or radiographs taken regarding treatment for use in lectures/demonstration. I understand that both 2D and 3D radiographs are for the purpose of dental and orthodontic diagnosis and are in no way intended for medical diagnosis.

Signature (adult signature if patient is a minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT DENTAL HISTORY**

**How did you hear about Preston Orthodontics?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dentist Friend Family member is a patient Internet



Bottom of Form

Date of your last dental examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_General Dentist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Top of Form

Have you ever had an orthodontic consultation or treatment? Yes No Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Bottom of Form

Top of Form

Any family members require/receive orthodontic treatment? Yes No Office\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Bottom of Form

Please notify past/present history of:

Top of Form

\_\_\_\_\_\_\_\_Thumb/Finger Sucking \_\_\_\_\_\_\_Jaw joint soreness \_\_\_\_\_\_\_\_\_Clenching teeth

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\_\_\_\_\_\_\_\_Tongue Thrusting \_\_\_\_\_\_\_Jaw joint clicking \_\_\_\_\_\_\_\_\_Grinding teeth

\_\_\_\_\_\_\_\_Mouth Breathing \_\_\_\_\_\_\_Jaw joint popping \_\_\_\_\_\_\_\_\_Muscle soreness (head and neck)

\_\_\_\_\_\_\_\_Lip Biting \_\_\_\_\_\_\_Ringing in the ears \_\_\_\_\_\_\_\_\_Frequent Headaches

**PATIENT MEDICAL HISTORY**

Top of Form

Present State of Health: Excellent Good Fair Poor Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Do you have any general health problems or under a physician’s care for an existing condition? Yes No



Please specify here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a past or present history of taking any medications for Osteoporosis or other bone diseases (Bisphosphonates – ie: Fosamax, Actonel, Boniva, Reclast)? Yes No



Please list current drugs/medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any drug allergies/sensitivities\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check those applicable if you have a history of:

Rheumatic Fever Hepatitis HIV/AIDS Tuberculosis



Jaundice Anemia Blood Disease Prolonged bleeding



Diabetes Swollen ankles Bone Disease Prosthetic implants



Convulsions Autism ADHD/ADD Psychiatric care Dental fear/anxiety



Difficult chewing/swallowing Speech impediments Asthma/hay fever/allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Repeated sore throats/colds Latex allergy Nickel allergy



Heart Condition Pre-medication required = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



History of visits to an ENT (Ear/Nose/Throat Dr) ENT Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tonsils removed?\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_ Adenoids removed?\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_/\_\_\_\_/\_\_\_\_

**Is there anything else about you (or your child) that will help our treatment to be the best experience possible?** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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