SAWYER ORTHODONTICS

Dr. Amy Smith Sawyer

PATIENT INFORMATION for PATIENTS UNDER 18 YEARS OF AGE

Date:_____

Name:_____
Last First Middle

Address_____
Street City Zip

Nickname_____Birthdate_____Social Security #_____
School_____Sports/Hobbies_____
Parent/Guardian(s)_____
Siblings (names, ages)_____
Other family members treated at our office_____
Who may we thank for referring you to our office?_____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Address_____
Street City Zip

How long at this address?_____Own or Rent?_____
Home Phone_____Work Phone_____
Cell/Other Phone_____Email Address_____
Social Security#_____Birthdate_____Relationship to Patient_____
Employer_____Occupation_____
Spouse's Name_____Spouse's Phone_____
Best number to contact you? (circle one) Home Work Cell/Other

DENTAL INSURANCE INFORMATION

**Please provide all information below. It is necessary to verify your orthodontic benefits.*

Policy Holder's Name_____Policy Holder's SSN#_____
Policy Holder's DOB_____Insurance Company_____
Member ID_____Group No._____
Insurance Co. Address_____
Insurance Co. Phone _____
Policy Holder's Address_____

EMERGENCY CONTACT

Name_____Phone _____

I understand that, where appropriate, credit bureau reports may be obtained. (Please note: Credit reports obtained by our office have no effect on credit scores and will not appear on credit reports.)

Parent/Guardian Signature_____
Updates (date & initial)_____

MEDICAL HISTORY

Physician_____Date of Last Visit_____
Address_____Phone_____
Please circle Yes or No (if yes, please explain):

Yes No Is the patient taking any medication (prescribed or non-prescribed)?_____
Yes No Is the patient allergic to any medication?_____
Yes No History of a major illness?_____
Yes No Has the patient had any operations?_____
Yes No Ever been involved in a serious accident?_____
Yes No Has the patient seen a physician in the last 12 months? Why?_____
Female Patients only:
Yes No Has menstruation started?_____
Yes No Is the patient pregnant?_____

Circle any of the medical conditions below that the patient has had or currently has:

Abnormal bleeding/Hemophilia	Diabetes/Endocrine Disorders	Hepatitis/Liver Problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High/Low Blood Pressure	Radiation/Chemotherapy
Asthma/ Hayfever	Gastrointestinal Disorders	HIV/Aids	Rheumatic Fever
Bone Disorders	Heart Problems/Heart Attack	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

DENTAL HISTORY

General Dentist_____Date of Last Visit_____
What concerns you most about your teeth?_____

Yes No Is the patient presently in any dental pain?_____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Has the patient ever lost or chipped any teeth?_____
Yes No Have there been any injuries to face, mouth, or teeth?_____
Yes No Is any part of your mouth sensitive to temperature? Where?_____
Yes No Is any part of your mouth sensitive to pressure? Where?_____
Yes No Do gums bleed when brushing?_____
Yes No Any type of thumb or tongue habit?_____
Yes No Is the patient a mouth breather?_____
Yes No Has the patient ever seen an orthodontist? If yes, who and when?_____
Yes No What is the patient's attitude toward receiving orthodontic treatment?_____
Yes No Has anyone in the family received orthodontic treatment?_____
How did they feel about the result?_____
Yes No Do teeth or jaws every feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day?_____
Yes No Experience "tension" headaches or migraines?_____
Yes No Has the patient ever experienced chronic ringing in the ears?_____
Yes No Does the patient need extra help with instructions?_____
Yes No Is the patient sensitive or self-conscious about his/her teeth?_____
Yes No Height of parent? Dad _____ Mom_____
Yes No Are you aware that some appointments will be during school hours?_____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function: Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Sawyer to perform a complete orthodontic evaluation.

Signature_____Date_____