



# CENTRAL MINNESOTA ORTHODONTICS

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Date \_\_\_\_\_

Patient's Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home phone \_\_\_\_\_  
Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Patient's special interests/hobbies/musical instruments \_\_\_\_\_  
Would you like e-mail appointment reminders? \_\_\_\_\_ E-mail address \_\_\_\_\_

Mother/Guardian's name \_\_\_\_\_ Home phone \_\_\_\_\_  
Employed by \_\_\_\_\_ Business phone \_\_\_\_\_  
Father/Guardian's name \_\_\_\_\_ Home phone \_\_\_\_\_  
Employed by \_\_\_\_\_ Business phone \_\_\_\_\_  
Parent(s) are: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_  
Notify in case of emergency \_\_\_\_\_ Phone number \_\_\_\_\_

Dentist or person who referred you \_\_\_\_\_  
Attending General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Names of other family members treated in our office \_\_\_\_\_  
Have you been referred here for any reason other than braces? \_\_\_\_\_  
Have you been evaluated at another orthodontic office? Yes/No If yes, by whom? \_\_\_\_\_

I understand that there is no charge for this initial exam. However, if further treatment is needed, charges will apply.  
Please initial \_\_\_\_\_

For the following questions circle yes, no, or don't know/understand (dk/u). The answers are considered confidential.

### DENTAL HISTORY:

- |                                                                   |                                                                   |
|-------------------------------------------------------------------|-------------------------------------------------------------------|
| yes no dk/u Baby teeth lost early?                                | yes no dk/u Jaw pain or ringing in ears?                          |
| yes no dk/u Missing any permanent teeth?                          | yes no dk/u Soreness in muscles of the face or around the ears?   |
| yes no dk/u Chipped or injured teeth?                             | yes no dk/u Difficulty chewing or opening mouth?                  |
| yes no dk/u Teeth sensitive to hot or cold?                       | yes no dk/u Aware of any loose, broken or missing fillings?       |
| yes no dk/u Jaw fractures, cysts, mouth infections?               | yes no dk/u Any teeth irritate lip, tongue or roof of mouth?      |
| yes no dk/u Bleeding gums, bad taste or odor?                     | yes no dk/u Aware or concerned about under or over developed jaw? |
| yes no dk/u Periodontal "gum" problems?                           | yes no dk/u Any relative with similar tooth or jaw conditions?    |
| yes no dk/u Food impacted "caught" between teeth?                 | yes no dk/u Any wisdom tooth problems?                            |
| yes no dk/u "Gum boils", canker sores, cold sores?                | yes no dk/u Any complications with prior dental treatment?        |
| yes no dk/u Thumb/finger sucking habit? Until _____               | yes no dk/u Does patient want braces?                             |
| yes no dk/u Abnormal swallowing habit (tongue thrust)?            | How often does patient floss _____                                |
| yes no dk/u History of speech problems?                           | How often does patient brush _____                                |
| yes no dk/u Mouth breathing habit, snoring, difficulty breathing? | yes no dk/u Does patient need antibiotics prior to dental care?   |
| yes no dk/u Tooth grinding, jaw clenching, clicking or locking?   |                                                                   |

### Doctor's Notes:

(Please complete back page)

**MEDICAL HISTORY:**

yes no dk/u Birth defects or hereditary problems?  
yes no dk/u Bone fractures, any major accidents?  
yes no dk/u Rheumatoid or arthritic conditions?  
yes no dk/u Endocrine or thyroid problems?  
yes no dk/u Kidney problems?  
yes no dk/u Diabetes?  
yes no dk/u Cancer or been treated for a tumor?  
yes no dk/u Stomach ulcer or hyperacidity?  
yes no dk/u Polio, mono, tuberculosis, pneumonia?  
yes no dk/u Problems of the immune system?  
yes no dk/u Recent loss of weight, poor appetite?  
yes no dk/u Anemia or bleeding disorder?  
yes no dk/u Skin disorder?  
yes no dk/u Frequent headaches or sore throats?  
yes no dk/u Tires easily?  
yes no dk/u Hayfever, asthma, sinus trouble?  
yes no dk/u Eye, ear, nose, throat condition?  
yes no dk/u High or low blood pressure?  
yes no dk/u Vision, hearing, tasting or speech difficulties?

yes no dk/u Chest pain, shortness of breath or swelling ankles?  
yes no dk/u AIDS or HIV positive?  
yes no dk/u Hepatitis, jaundice or liver problem?  
yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?  
yes no dk/u ADHD, behavioral problems, depression?  
yes no dk/u Cardiovascular or heart problems inborn heart defects or rheumatic fever?  
yes no dk/u Past or current substance abuse?  
yes no dk/u Drug or Food allergies? If so what kind?  
yes no dk/u Operations or surgical procedures?  
yes no dk/u Taking medication, supplements or over the counter medicine? If so, which ones?  
\_\_\_\_\_  
yes no dk/u Hospitalized for \_\_\_\_\_  
yes no dk/u Being treated by another health care professional for \_\_\_\_\_  
Date of most recent physical exam \_\_\_\_\_

Any problem(s) not mentioned above: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

**ORTHODONTIC INSURANCE:**

1) Primary orthodontic insurance company name and address \_\_\_\_\_

\_\_\_\_\_  
ID # or SSN# \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Subscriber Birth date \_\_\_\_\_  
Subscriber Employer \_\_\_\_\_

2) Secondary orthodontic insurance company name and address \_\_\_\_\_

\_\_\_\_\_  
ID # or SSN# \_\_\_\_\_ Group # \_\_\_\_\_  
Subscriber name \_\_\_\_\_ Subscriber Birth date \_\_\_\_\_  
Subscriber Employer \_\_\_\_\_

Successful treatment greatly depends upon the patient's complete cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any physical restrictions, handicaps or scheduling problems that we should be aware of?

\_\_\_\_\_

I have read and understand the above questions. I will not hold my orthodontist or any member of Central Minnesota Orthodontics responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this office.

\* \_\_\_\_\_ \* \_\_\_\_\_ \* \_\_\_\_\_  
Signature of Parent or Guardian Date Health History Update Signature Date Signature of Orthodontist Date

**I have received a copy of this office's Notice of Privacy Practices (HIPAA). Please initial \_\_\_\_\_**