LANE ORTHODONTICS

Patient Information **Date:**

Patient's Name_____
Last First Middle (Nickname or Preferred name)

Address_____
Street City Zip

Phone_____ Birthdate_____ Gender M F

If Patient is a minor, who is accompanying today? (relationship)_____

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

Responsible Party Information

Name_____
Last First Middle

Address_____
Street City Zip

Cell Phone_____ Home Phone_____

Email (appointment reminders will be sent here)_____

Employer_____ Occupation_____

Spouse's Name_____ Relationship to Patient_____

Spouse's Employer_____ Occupation_____

Dental Insurance Information

Subscriber's Name_____ Relationship to patient_____

Insurance Company_____ Group #_____

Insurance Company Address_____ Phone_____

Subscriber's Birthdate_____ Insurance ID# or SSN _____

Do You Have Secondary Coverage? Yes No if yes please fill in below:

Subscriber's Name_____ Relationship to patient_____

Insurance Company_____ Group #_____

Insurance Company Address_____ Phone_____

Subscriber's Birthdate_____ Insurance ID# or SSN _____

Emergency Information

Emergency Contact_____ Phone_____

Address_____
Street City Zip

Medical History

Physician_____ Date of last Visit_____

Address_____ Phone_____

Please Circle Yes or No (if Yes, Please fill in details)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Do you have a history of an illness/ hospital stays?_____
Yes No Have you had any major operations?_____
Yes No Have you ever been involved in a serious accident?_____

Patients Overall current physical health: Excellent_____ Good_____ Fair_____ Poor_____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/ Hemophilia	Bone Disorders/ Artificial joints	Handicaps	Lupus Nervous Disorders
ADD/ ADHD	Congenital Heart Defect	Hepatitis	Pneumonia
Alcohol/ Drug Abuse	Diabetes	Herpes	Prolonged Bleeding
Allergies to Latex/ Metals	Dizziness	High Blood Pressure	Radiation/ Chemotherapy
Anemia	Epilepsy	HIV/ AIDS	Rheumatic Fever
Arthritis	Gastrointestinal Disorders	Kidney Problems	Tuberculosis
Asthma or Hay Fever	Heart Problems	Liver Problems	Tumor or Cancer

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

_____

Dental History

Dentist_____ Date of last Visit_____

Please explain your main orthodontic concern:_____

Yes No Are you aware that orthodontic treatment is dependent on patient cooperation?
Yes No Have you or any family members received orthodontic treatment?_____
Yes No Have you ever had any unfavorable reaction to dentistry?_____
Yes No Have you ever lost or chipped any teeth?_____
Yes No Have there been any injuries to mouth, face or chin?_____
Yes No Do you brush daily?
Yes No Do your gums bleed when you brush?
Yes No Have you ever had a habit of sucking your thumb?
Yes No Are you a mouth breather?
Yes No Do you play an instrument? Please list_____
Yes No Do your teeth or jaw ever feel sore or does it ever click or pop?
Yes No Are you aware of clenching or grinding your teeth?
Yes No Do you have “tension” headaches or frequent ringing in your ears?
Yes No Are you aware that some appointments must be during school or work hours?
Yes No Has Puberty begun?

Female Patients Only:

Yes No Are you pregnant?
Yes No Has menstruation started?

I have truthfully answered all the above questions and agree to inform this office of any changes in my (my child’s) medical or dental health. In addition, I authorize Dr. Carter A. Lane to perform a complete orthodontic evaluation.

Signature (Parent’s Signature if minor)_____ Date_____

Updates (date & Initial)_____

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