ANCHORAGE ORTHODONTIC ASSOCIATES
1000 O'Malley Road, Suite 105
Anchorage, AK 99515-3032
(907)349-1951

DATE_____ Age (Yr-Mo)_____
Recall_____ Age (Yr-Mo)_____
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PATIENT INFORMATION

Patient's Name_____ Birthday _____ Sex: [ ] M [ ] F
First Middle Last

Address_____ City_____ Zip_____ Hm. Phone_____

Employer (Adult)/School (Child)_____ Occupation/Grade_____ Wk. Phone_____

E-mail Address_____ Cell Phone_____ Patient's Dentist_____

Referred by_____ Physician_____ Patient Adopted? [ ] Yes [ ] No

Patient covered by orthodontic insurance? [ ] Yes [ ] No Insurance Company_____

FAMILY INFORMATION

(Complete only if patient is not responsible for account and if different from above information)

Father_____ _____
Name Address City Zip Phone

Employer_____ Occupation_____ Wk. Phone_____

Mother_____ _____
Name Address City Zip Phone

Employer_____ Occupation_____ Wk. Phone_____

[ ] Single [ ] Married [ ] Separated [ ] Divorced

Other children in family_____
Names and Ages

Have they had orthodontic treatment? [ ] Yes [ ] No If yes, name of orthodontist_____

Person responsible for account: Name_____ Soc. Sec. #_____

MEDICAL HISTORY

Person completing this form_____ Relationship_____

Is patient in good health? [ ] Yes [ ] No Is patient presently under a physician's care? [ ] Yes [ ] No For:_____

Date of last dental exam and dental cleaning_____ Dentist_____

Does patient currently have (or has patient previously had) any of the following conditions? Please check any which apply.

[ ] Diabetes	[ ] Tuberculosis	[ ] Hormone/Growth Problems	[ ] Glaucoma	[ ] Kidney Disease
[ ] Pneumonia	[ ] Anemia	[ ] Prolonged Bleeding	[ ] VD	[ ] Liver Disease
[ ] Heart Disease	[ ] Epilepsy	[ ] Fainting or Dizziness	[ ] Hepatitis	[ ] High/Low Blood Pressure (Circle)
[ ] Rheumatic Fever	[ ] Asthma	[ ] Pregnant Now	[ ] HIV/AIDS	[ ] Nervous Disorder(s)
[ ] Bone Disorders	[ ] Smoking/Tobacco Use	[ ] Other (List)_____		

Patient tendencies: [ ] colds [ ] sore throats [ ] ear infections. Have tonsils and adenoids been removed? [ ] Yes [ ] No What age?_____

Current medications_____ **Allergies**_____

Girls: Has menstruation begun? [ ] Yes [ ] No What age?_____ **Boys:** Has voice changed? [ ] Yes [ ] No What age?_____
Height_____ Weight_____ Is growth complete? [ ] Yes [ ] No [ ] Unsure Height of same sex parent_____

What is your main concern for this visit? [ ] Dentist referred [ ] Crowding [ ] Spacing [ ] Crooked Teeth [ ] Overbite or Overjet
[ ] Small lower jaw [ ] Underbite [ ] Large lower jaw [ ] Crossbite [ ] Deepbite [ ] Openbite [ ] TMJ [ ] Other_____

How does the patient feel about wearing braces or appliances? [ ] Excited [ ] Neutral [ ] Negative

What are the expectations from orthodontic treatment?_____

Have there been any injuries to the face, mouth or teeth?	[ ] Yes [ ] No	Describe_____	
Has the patient ever sucked thumb or fingers?	[ ] Yes [ ] No	Describe_____	
History of biting lips, tongue, cheek, fingernails, other object?	[ ] Yes [ ] No	Describe_____	
Does the patient have any speech problems?	[ ] Yes [ ] No	Describe_____	
Has there been speech therapy?	[ ] Yes [ ] No	Describe_____	
Does the patient clench, grind or grit his/her teeth at night?	[ ] Yes [ ] No	Describe_____	
Does the patient have any clicking, popping or pain in the TMJ?	[ ] Yes [ ] No	Describe_____	
Does the patient play a musical instrument with the mouth?	[ ] Yes [ ] No	What Instrument?_____	

Family history of: [ ] missing teeth [ ] impacted teeth [ ] small lateral incisors [ ] ortho treatment [ ] TMJ [ ] Class III bite (underbite)

Signature_____ Date_____