RISINGER ORTHODONTICS

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Patient Information

Patient's Name _____

Prefers to be called _____

Patient Sex:

PATIENT INFORMATION

FIRST& LAST NAME: BIRTHDATE: AGE:

MAILING ADDRESS: HOME PHONE:

WORK PHONE: _____ SCHOOL: _____ GRADE: _____

EMPLOYED BY/OCCUPATION: _____ CELL PHONE: _____

EMAIL: _____ ***(PARENTS EMAIL IF PATIENT IS A MINOR)*** YOU WILL BE ALLOWED 24 HOUR ACCESS TO YOUR APPOINTMENT INFORMATION, ACCOUNT INFORMATION, AND YOUR PHOTOGRAPHS/X-RAYS.

WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY _____ PHONE: _____

EMERGENCY CONTACTS RELATIONSHIP TO PATIENT: _____

NAME OF GENERAL DENTIST: _____ DATE OF LAST VISIT: _____

RELATED PATIENTS THAT HAVE BEEN UNDER OUR CARE: _____

NAMES & AGES OF OTHER CHILDREN: _____

HOW DID YOU HEAR ABOUT US? ☐ GENERAL DENTIST ☐ YELLOW PAGES ☐ INTERNET SEARCH

☐ FRIEND Name: _____ ☐ OTHER: _____

PARENT INFORMATION (please complete if patient is a minor)

SINGLE☐ MARRIED☐ DIVORCED☐ SEP☐ WIDOW(ER)☐ PATIENT IS LIVING WITH: _____

FATHER'S NAME: _____

ADDRESS(if different than patients): _____

CITY: _____ ST: _____ ZIP: _____

PHONE (H): _____ PHONE (W): _____

PHONE (C): _____ SSN: _____

EMPLOYER: _____

MOTHER'S NAME: _____

ADDRESS(if different than patients): _____

CITY: _____ ST: _____ ZIP: _____

PHONE (H): _____ PHONE (W): _____

PHONE (C): _____ SSN: _____

EMPLOYER: _____

INFORMATION ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME: _____ RELATIONSHIP TO PATIENT: _____ EMPLOYED BY/OCCUPATION: _____

MAILING ADDRESS: _____ CITY: _____ ST: ____ ZIP: _____

PHONE (H): _____ IF DIVORCE IS INVOLVED, WHO IS THE CUSTODIAL PARENT? _____

MAY PATIENT INFORMATION BE RELEASED TO THE NONCUSTODIAL PARENT? YES☐ NO☐

(Continued on next page)

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Patient Information

Patient's Name

MEDICAL HISTORY

Please check if patient has or has had:

Yes	No		Yes	No	
☐	☐	Joint swelling	☐	☐	Tuberculosis
☐	☐	Bone disorders	☐	☐	Anemia
☐	☐	Heart trouble	☐	☐	Epilepsy
☐	☐	Mitral Valve prolapse	☐	☐	Prolonged bleeding
☐	☐	Rheumatic trouble	☐	☐	Faintness/Dizziness
☐	☐	Thyroid problems	☐	☐	Tonsils removed
☐	☐	Diabetes	☐	☐	Adenoids removed
☐	☐	Emotional problems	☐	☐	Sore throats
☐	☐	Kidney or liver involvement	☐	☐	Tonsillitis
☐	☐	Joint prosthesis	☐	☐	Arthritis
☐	☐	Cancer	☐	☐	High blood pressure
☐	☐	Smoke			
☐	☐	Do you need antibiotic premedication prior to dental cleanings?			
☐	☐	Have you ever taken any bisphosphonate medications? (ex. fosamax, actonel, boniva, aredia, or zometa)			

On items checked "YES", please provide us with a more detailed description:

DENTAL HISTORY

Please check Yes or No:

Yes	No	
☐	☐	Any injuries to face, mouth, teeth? (circle)
☐	☐	Thumb, finger, lip sucking? (circle)
☐	☐	More than average amount of decay?
☐	☐	Any missing permanent teeth?
☐	☐	Any extra permanent teeth?
☐	☐	Any teeth removed by extraction?
☐	☐	Any difficulty in swallowing or chewing?
☐	☐	Any pain or clicking on opening mouth?
☐	☐	Is patient adopted? At what age? _____
☐	☐	Does patient visit dentist regularly? Date of last visit? _____
☐	☐	Do your gums ever bleed?
☐	☐	Have you ever experienced pain/discomfort in your jaw joint (TMJ)?
☐	☐	Do you like to smile?

On items checked "YES", please provide us with a more detailed description:

WHAT ARE YOUR MAIN CONCERNS THAT YOU WOULD LIKE ORTHODONTICS TO ADDRESS? _____

_____

PATIENTS ATTITUDE TOWARD ORTHODONTIC TREATMENT (circle one): very motivated will cooperate if needed not motivated

HAVE YOU EVER HAD OR BEEN EVALUATED FOR ORTHODONTIC TREATMENT? Yes ☐ No ☐ If yes, when?_____

HAVE YOU OR ANY MEMBER OF YOUR FAMILY OR CLOSE RELATIVES HAD: Rheumatoid Arthritis? Yes ☐ No ☐
Lupus? Yes ☐ No ☐

APPROXIMATELY HOW MUCH HAS PATIENT GROWN IN THE LAST YEAR: _____

IF FEMALE, IS THERE A POSSIBILITY YOU ARE PREGNANT? Yes ☐ No ☐ If yes, how many weeks?_____

LIST ANY SERIOUS ILLNESSES: _____

LIST ANY ALLERGIES: _____

LIST DRUGS OR MEDICATIONS CURRENTLY BEING TAKEN: _____

IS PATIENT PRESENTLY UNDER PHYSICIAN 'S CARE? REASON: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____
Date

_____
Signature of Patient/ Parent if Patient is a minor