



Badger & Spiller
Orthodontics for Children and Adults

PATIENT INFORMATION

NAME: (last) _____ (first) _____ (mi) _____ (nickname) _____
ADDRESS: _____
PHONE: _____ BIRTHDATE: ____ / ____ / ____ SSN #: _____
E MAIL ADDRESS: _____ HOBBIES: _____
HOW DID YOU HEAR ABOUT OUR OFFICE: _____
SCHOOL YOU ATTEND: _____ GRADE: _____ AGE: _____

FAMILY INFORMATION (please complete only if patient is a minor)

FATHER'S NAME: _____ MOTHER'S NAME: _____
ADDRESS (if different) _____ ADDRESS: _____
EMPLOYER: _____ HOW LONG _____ EMPLOYER: _____ HOW LONG _____
PHONE #: _____ PHONE #: _____
BUSINESS PHONE #: _____ BUSINESS PHONE #: _____

RESPONSIBLE PARTY INFORMATION

NAME (last, first, mi): _____ MARITAL STATUS _____
ADDRESS (if different): _____
HOME PHONE #(if different): _____

INSURANCE INFORMATION DENTAL

NAME OF INSURANCE: _____
ADDRESS: _____
PHONE #: _____ GROUP #: _____
NAME OF INSURED AND BIRTHDATE: _____
INSURED ID#: _____ NAME OF EMPLOYER: _____
ADDRESS: _____

IF THERE IS A SECONDARY INSURANCE PLEASE ASK FOR ANOTHER FORM. THANKS

EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU: _____
ADDRESS: _____
PHONE #: _____ RELATIONSHIP: _____

MEDICAL HISTORY

PHYSICIAN'S NAME _____

HAS PATIENT HAD ANY OF THE FOLLOWING (CIRCLE Y OR N)?

- | | |
|---------------------------------------|-------------------------------------|
| Y N HEART PROBLEMS/MURMUR | Y N ALLERGIES TO MEDICINE |
| Y N HIGH BLOOD PRESSURE | Y N GENERAL ALLERGIES |
| Y N ARTIFICIAL HEART VALVES OR JOINTS | Y N TONSILLITIS |
| Y N DIABETES | Y N AIDS (AUTOIMMUNE DISEASES) |
| Y N RESPIRATORY DISEASE | Y N VENEREAL DISEASE |
| Y N EPILEPSY | Y N HEMOPHILIA (BLEEDING DISORDERS) |
| Y N HEADACHES | Y N RHEUMATIC FEVER |
| Y N HEPATITIS LIVER DISEASE | Y N RECENT UNEXPECTED WEIGHT LOSS |
| Y N EMOTIONAL DISORDERS | Y N OTHER, SPECIFY _____ |

PRESENT STATE OF HEALTH: EXCELLENT GOOD POOR

IS PATIENT TAKING MEDICINE AT THIS TIME? YES NO IF SO, WHAT _____

IS PATIENT PRESENTLY UNDER PHYSICIAN'S CARE? YES NO WHAT CONDITION _____

IF PATIENT IS A CHILD WHAT IS HIS/HER WEIGHT? _____ HEIGHT _____

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR MEDICAL HISTORY? _____

REVIEWED _____ DATE _____

DENTAL HISTORY

NAME OF YOUR DENTIST: _____

HAS PATIENT HAD: (CIRCLE Y OR N)?

- | | | |
|---------------------------------------|-----------------------------|---------------------|
| Y N RECENT DENTAL X-RAYS | Y N PERIODONTAL TREATMENT | Y N IMPRESSIONS |
| Y N TEETH CLEANED RECENTLY | Y N RECENT FILLINGS, CROWNS | Y N DENTAL CHECK UP |
| Y N FLUORIDE TREATMENT | Y N TRAUMA TO FACE/MOUTH | Y N TMJ SPLINT |
| Y N PREVIOUS ORTHODONTIC CONSULTATION | | |

WHAT DO YOU CONSIDER THE MAIN BENEFIT OF ORTHODONTIC TREATMENT? FUNCTIONAL COSMETIC PSYCHOLOGICAL

IS PATIENT SELF-CONSCIOUS OF HIS/HER TEETH? YES NO

HAVE WE TREATED OTHERS IN YOUR FAMILY? YES NO WHO _____

DOES PATIENT HAVE PAST/PRESENT HISTORY OF:

- | | |
|--------------------|------------------------------------|
| Y N TONGUE THRUST | Y N MOUTH BREATHING |
| Y N THUMB SUCKING | Y N SPEECH IMPEDIMENT |
| Y N FINGER SUCKING | Y N TMJ |
| Y N NAIL BITING | Y N POPPING, CLICKING IN JAW JOINT |

THIS FORM WAS COMPLETED BY: (CIRCLE) PATIENT PARENT GUARDIAN.

SIGNATURE: _____ **DATE:** _____