Patient Information

DELIO ORTHODONTICS

Date _____

Name _____ Age _____ Phone _____
Address _____ Birthdate _____ School _____
City/State/Zip _____ Sex _____ Grade _____
Person and phone number to contact in case of emergency _____
Whom may we thank for referring you? _____
Any interest/hobbies you care to share with us? _____

Responsible Party Information

Parent's Name _____
Address _____
City/State/Zip _____
Home Phone _____ Email _____
Name of Person Responsible for this account _____ Relationship to Patient _____
Address _____
City/State/Zip _____
Phone _____ Social Security # _____
Employer _____ Work Phone _____

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Insured's Social Security # _____ Insurance Company _____
Insurance Company Claims Mailing Address _____
City/State/Zip _____
Group # _____ Insurance Company Toll Free # _____
Employer ID# _____ Insured Date of Birth _____

Patient Medical History

Physician _____ Date of Last Exam _____
Address _____ Phone # _____

Please circle Yes or No(if Yes, please fill in details)

Yes No Are you taking any medication(s) including non-prescription medicine? _____
_____

Yes No Are you allergic to or have you had any reaction to the following (circle applicable)?
Penicillin or other antibiotics Pain Relievers Other _____

Yes No Are you pregnant or do you think you may be pregnant?

Yes No Do you have a history of a major illness?

Yes No Have you had any major operations?

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

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis	Pneumonia
Anemia	Dizziness	Herpes	Rheumatic Fever
Arthritis	Epilepsy	High Blood Pressure	Tonsils Removed
Asthma/Hayfever	Fainting	HIV/Aids	Thyroid Problems
Bone Disorders	Heart Disease	Kidney Problems	Tuberculosis
Chemotherapy/Radiation	Heart Murmur	Joint Replacement	Tumor or Cancer

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

Patient Dental History

Dentist _____ Date of Last Dental Exam_____
What is your concern about your teeth? _____
Any previous orthodontic treatment (if yes please explain) _____
_____

Yes	No	Do your gums bleed while brushing or flossing?
Yes	No	Are your teeth sensitive to hot, cold or to sweets?
Yes	No	Were any baby or permanent teeth lost due to decay?
Yes	No	Do you feel pain to any of your teeth?
Yes	No	Do you have any sores or lumps in or near your mouth?
Yes	No	Pain in your jaw joint?
Yes	No	Difficulty in opening or closing?
Yes	No	Do you clench or grind your teeth?
Yes	No	Do you bite your lips or cheeks frequently?
Yes	No	Do you suck your thumb?
Yes	No	Have you ever had any difficult extractions in the past?
Yes	No	Have you ever had any prolonged bleeding following extractions?
Yes	No	Have you ever had instruction on the correct method of brushing?
Yes	No	Have you ever had instruction on the care of your gums?
Yes	No	Do you have a latex allergy?

Dr.’s Notes