Petrol
Orthodontics

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Patient Information

Today's Date ____________________

Patient's Name ____________________ Prefers to be called ____________________

Address ____________________

City, State, ZIP ____________________

Home Phone ____________________ Birthdate ________ Age ________ Sex ____

Cell Phone ____________________ Email ____________________

School Name ____________________

Family Dentist ____________________ Date of last visit ____________________

What would you like orthodontic treatment to accomplish? ____________________

____

____

Which are you most interested in? ☐ Invisalign ☐ Clear Braces ☐ Metal Braces

Who may we thank for referring the patient to Petrol Orthodontics? ____________________

Father's Name ____________________ Birthdate ________ Wk. Ph. ____________

Occupation ____________________ Employer ____________________

Cell Phone ____________________ Email ____________________

Mother's Name ____________________ Birthdate ________ Wk. Ph. ____________

Occupation ____________________ Employer ____________________

Cell Phone ____________________ Email ____________________

If divorce is involved, who is the Custodial Parent? ____________________

May the patient information be released to the Noncustodial Parent? ☐ NO ☐ YES

Non-Custodial Parent's Address ____________________

City, State, ZIP ____________________

Name of person financially responsible for the account ____________________

Cell Phone ____________________ Email ____________________

Brothers and Sisters:

Name ________________ Birthdate ______ Name ________________ Birthdate ______

Name ________________ Birthdate ______ Name ________________ Birthdate ______

Does the patient have orthodontic insurance coverage? ☐ NO ☐ YES, Company ____________

Insurance Company Address ____________________

City, State, ZIP ____________________

Name of Insured ____________________ SS# ____________________

Group Number ____________________ Phone/Contact ____________________

Dual coverage? ☐ NO ☐ YES, Company ____________________ Employer ____________

Signature ____________________

Health History

Family Physcian________________________________ Phone ______________________________

Does the patient have or has had any of the following medical conditions? *Check all that apply*

☐ Rheumatic or Scarlet Fever
☐ Heart murmur
☐ Heart conditions ____________
☐ Diabetes
☐ Anemia
☐ Arthritis, swollen joints
☐ Inflammatory Rheumatism
☐ Kidney problems
☐ Tuberculosis
☐ Asthma/Hay fever
☐ Glaucoma
☐ Hepatitis type ______________
☐ Liver Disease
☐ High blood pressure
☐ Low blood pressure
☐ Severe headaches
☐ Dizziness or fainting
☐ Epilepsy or seizures
☐ Eye problems
☐ Ear problems
☐ Sinus problems
☐ Bleeding disorders/Anemia
☐ Speech problems
☐ Swallowing problems/tongue thrusting
☐ Easy bruising
☐ STD
☐ HIV positive
☐ ADD/ADHD
☐ Endocrine problems
☐ Autism/Aspergers
☐ Neurological disorders
☐ Thyroid problems
☐ Other illness ______________

Has the patient ever had the following dental treatment? *Check all that apply*

☐ Orthodontics_______________________ Date______________ by Dr. ______________________
☐ Periodontal treatment (gum treatment)
☐ Oral surgery/treatment
☐ Mouthguard or splint therapy for jaw joint problems
☐ Bite adjustment
☐ Jaw surgery to change your bite or to correct jaw joint
☐ Tongue thrust therapy

Does the patient have or has had any of the following oral conditions? *Check all that apply*

☐ Clenching or grinding
☐ Oral habits (thumb sucking, etc.)
☐ Food wedging between teeth
☐ Pain in the jaw, ear or face
☐ Bleeding gums
☐ Discolored teeth
☐ Jaw joint sounds, clicking/pain
☐ Mouth breathing
☐ Missing or extra permanent teeth
☐ Jaw locking open or closed
☐ Dry mouth
☐ Inability to floss between teeth
☐ Frequent headaches
☐ Bad breath
☐ Sensitive teeth

Y/N

☐ ☐ Does the patient brush 3 times daily?
☐ ☐ Does the patient floss daily?
☐ ☐ Has the patient ever had injuries to face/mouth/teeth? If yes, describe ________________________
☐ ☐ Is the patient currently under a physician's care? If yes, describe ____________________________
☐ ☐ Has the patient ever been hospitalized or had any serious illness? If yes, describe ________________
☐ ☐ Is the patient taking any medication? If yes, list medications _________________________________
☐ ☐ Does the patient have any drug allergies? If yes, list medications ______________________________
☐ ☐ Is the patient allergic to latex, vinyl, metal or nickel? *Circle all that apply.*
☐ ☐ Does the patient snore? The patient's family members? If yes, list __________________________
☐ ☐ Does the patient use tobacco?
☐ ☐ Female patients - could patient possibly be pregnant at the present time?

The Patient or Parent Signature (if the patient is under 18 years)

____ Date ____________

Whom may we contact in case of emergency?

Name ___________________________________ Phone_________________

Updates (date & initial) _________/ ___________/ ___________/ ___________