Updates (date & initial)   A B C

Patient Information and Health History

Jaeger ▸ Curtis Orthodontics

Thank you for completing this information before your first visit.
It is a confidential part of our patient records.

1717 Lincoln Way
Suite 203
Coeur d'Alene, Idaho 83814
(208) 667-3341
(800) 735-1152

Exam Date ______________ Exam Time ______________ AM PM

Patient Information

Patient's Name ______________________________
Last First Middle Preferred Nickname

Address ______________________________
Street City State Zip

Home Phone ______________ Birthdate ______________ Age ______ Sex: ❏ M ❏ F Social Security # ______________

School Name (if applicable) ______________________________ School Grade Level ______________

Favorite Subjects ______________________________ Special Interests: hobbies, sports, etc. ______________

If the patient is a minor, give parent's or guardian's name ______________________________

Whom may we thank for referring you to our office? ______________________________

Responsible Party Information

Name (❏ Same as patient) ______________________________
Last First Middle Marital Status

Residence (❏ Same as patient) ______________________________
Street City State Zip

Mailing Address (❏ Same as above) ______________________________
Street City State Zip

How long at this address ______________ Home Phone ______________ Work Phone ______________

Previous Address (if less than 3 yrs.) ______________________________
Street City State Zip

Social Security # ______________ Birthdate ______________ Relationship to patient ______________

Employer ______________ Occupation ______________ No. of years employed ______

Spouse's Name ______________________________ Work Phone ______________

Employer ______________ Occupation ______________ No. of years employed ______

Social Security # ______________ Birthdate ______________ Relationship to patient ______________

Insurance Information

Insured's Name ______________________________ Insured's Social Security # ______________
Last First Middle

Insurance Company ______________ Group # ______________ Local # ______________

Insurance Company Address ______________________________
Street City State Zip

Do you have dual coverage? ❏ Yes ❏ No If yes:

Insured's Name ______________________________ Insured's Social Security # ______________
Last First Middle

Insurance Company ______________ Group # ______________ Local # ______________

Insurance Company Address ______________________________

Insured's Employer ______________________________
Street City State Zip

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________ Phone ______________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (parent's or guardian's signature if minor) ______________________________ Date ______________

(*continued on back*)

Minor Patient Growth Information (*if known*)

Height of: Patient ______ Father ______ Mother ______

Patient's brothers and sisters:

Name ______ Age ______ Height ______

Name ______ Age ______ Height ______

Name ______ Age ______ Height ______

Has any member of the family had orthodontic treatment? If yes, who and where.

______

Has the patient:

Had unusual growth rates	❑ Yes	❑ No
Reached puberty (generally signalled by voice changing in boys and menstrual cycle in girls)	❑ Yes	❑ No
Inherited family facial or dental characteristics	❑ Yes	❑ No
Had a family history of a similar dental condition	❑ Yes	❑ No

Patient Dental History

Patient's dentist ______

Has your dentist talked to you about an orthodontic concern? ❑ Yes ❑ No

What is your main concern for seeking this appointment? ______

______

Date of last dental visit for:

Examination ______ X-rays ______

Cleaning ______ Restorative work ______

Has all work been completed? ❑ Yes ❑ No

Check if patient has or has had:

- ❑ Extra teeth
- ❑ Missing teeth
- ❑ Gum disease or infection
- ❑ High rate of tooth decay
- ❑ Teeth sensitive to hot, cold, or sweets
- ❑ Swelling or lumps in the mouth

Check all that apply to patient	**Yes**	***If Yes, please explain***
Prior orthodontic evaluation		Date:
Prior orthodontic treatment		Date:
History of thumb or finger sucking		
Play a horn or other mouth instrument		
Breathes with mouth open		
Had a severe injury to the head, face, or teeth		Date:
Treatment for a jaw joint problem		Date:
History of clenching or grinding the teeth		
Does the patient's:	**Yes**	
Bite feel uncomfortable or unusual		
Jaw joint (TMJ) make noise or hurt when moving		
Does the patient have:	**Yes**	
Pain in or about the teeth, ears, temples, cheeks		
Frequent headaches		

Patient Medical History

Patient's doctor ______

Date of last medical exam ______

Check all that apply to patient	**Yes**	***If Yes, please explain***
Any health problems or allergies		
Is the patient now:	**Yes**	
Under a doctor's care		
Taking any medication(s)		List:
Mentally or physically challenged		
Has the patient ever:	**Yes**	
Been under a doctor's care		
Been treated in a hospital		
Taken any medication(s)		List:
Had an unfavorable reaction to any medication(s)		List:

Please check any of the following which the patient has or has had:

- ❑ Heart disease
- ❑ Rheumatic/Scarlet fever
- ❑ Heart murmur
- ❑ Bleeding problems
- ❑ Anemia
- ❑ Arthritis
- ❑ Bone disorders
- ❑ Prosthetic joint (replacement)
- ❑ Malignancies, tumors, cancers
- ❑ Liver problems
- ❑ Tuberculosis
- ❑ AIDS or HIV Positive
- ❑ Diabetes
- ❑ Thyroid or hormonal imbalance
- ❑ Kidney problems
- ❑ Asthma
- ❑ Tonsils removed at age ______
- ❑ Adenoids removed at age ______
- ❑ Difficulty breathing through the nose
- ❑ Cleft lip
- ❑ Cleft palate
- ❑ Speech problems
- ❑ Hearing problems
- ❑ Epilepsy
- ❑ Convulsions
- ❑ Fainting
- ❑ Dizziness
- ❑ Glaucoma
- ❑ Wears contact lenses

Are there any other dental or medical concerns we should be aware of?

______

______

______

Signature

This information is complete and accurate. If any information changes, I will notify the Jaeger▸Curtis Orthodontics office immediately.

______
Patient signature / Guardian signature of minor patient Date

Member American Association of Orthodontists

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