

Date: _____

Aspire Orthodontics

To aid us in better communication, we appreciate you filling out all forms completely.

Patient's Full Name: _____ Preferred Name: _____
Patient's Address _____ City _____ State _____ Zip _____
DOB _____ SSN _____ Marital Status _____ Male/Female _____
Home # _____ Cell # _____ Work # _____
Patient's E-mail (Used only for practice correspondence through T-Link): _____
Employer/School: _____ City _____ Grade _____
How long there? _____ Occupation _____ Best time to reach you? _____
Mother and father's full name if child: _____
Whom may we thank for referring you to us? _____
Other family members seen by us: _____

Responsible Party IF DIFFERENT FROM PATIENT

Full Name: _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
DOB _____ SSN _____ Marital Status _____ Male/Female _____
Home # _____ Cell # _____ Work # _____
E-mail: (Used only for practice correspondence through T-Link): _____
Employer: _____ City _____
How long there? _____ Occupation _____ Best time to reach you? _____
Is this person the Financially Responsible Party? **Y or N** Brings Patient to Appointment? **Y or N**

Spouse's Full Name: _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
DOB _____ SSN _____ Marital Status _____ Male/Female _____
Home # _____ Cell # _____ Work # _____
E-mail: (Used only for practice correspondence through T-Link): _____
Employer: _____ City _____

Emergency Contact: (nearest person not living with you)

Name: _____ Relationship to Patient: _____
Home # _____ Cell # _____ Work # _____
Address _____ City _____ State _____ Zip _____

Medical History

Have you been under the care of a physician in the past two years? **Y or N**
Please explain _____
Physician's Name _____ Phone # _____ Date of last visit _____
Do you require premedication before any dental appointments? **Y or N**
Please explain _____
Have you had any operations or hospitalizations? **Y or N**
Please explain _____
Do you smoke or use tobacco in any form? **Y or N**

Have you had and metal rods, pins, or implants? **Y or N**

Are you taking any prescription / over the counter drugs? **Y or N**

Please list _____

Have you ever taken bisphosphonates? (example, Actonel, Boniva, Fosamax, Skelid, Didronel, Aredia, Zometa or Bonefos) **Y or N** If so, When? _____

Please list any drugs and/or materials you are allergic to (Penicillin, Erythromycin, latex, aspirin, sulfa, anesthetics, sulfate, atropine, codeine, tetracycline, other): _____

Adolescent Patient reached puberty: **Y or N** At what age? _____

For women:

Are you taking birth control pills? **Y or N** Are you pregnant? **Y or N** Weeks #: _____

Are you trying to get pregnant? **Y or N** Are you Nursing? **Y or N**

Have you ever had any of the following disease or medical problems? (If yes, please circle and explain)

If none of the below, please circle: **NONE**

- | | | | |
|-------------------------|------------------------|--------------------------|-------------------------|
| Abnormal bleeding | Diabetes | Heart Surgery/ Pacemaker | Severe/ Freq. Headaches |
| Anemia | Difficulty Breathing | Hemophilia | Shingles |
| Artificial Bones/Joints | Drug/ Alcohol Abuse | Hepatitis | Sickle Cell Anemia |
| Birth Defects | Emphysema | High/ Low Blood Pressure | Sinus Problems |
| Bone Disorder | Epilepsy/ Seizures | HIV+/AIDS | Stroke |
| Asthma | Fainting/ Dizziness | Kidney/ Liver Problems | TMJ Discomfort |
| Arthritis | Fever Blisters/ Herpes | Mitral Valve Prolapse | Tuberculosis |
| Blood Transfusion | Glaucoma | Psychiatric Problems | Ulcers/ Colitis |
| Cancer/ Chemotherapy | Heart Attack | Radiation Treatments | Venereal Disease |
| Congenital Heart Defect | Heart Murmur | Rheumatic/ Scarlet Fever | |

Please explain _____

Dental History

What are the main concerns for coming to see us? _____

What would you like to see done to your smile? _____

Current Dentist: _____ Date of most recent dental cleaning/exam _____

Are you in need of dental work from your dentist? **Y or N** Explain _____

Have you ever had or been evaluated for orthodontic treatment? **Y or N**

Please explain any previous treatment or concerns _____

Do you have any of the following? (If yes, please circle and explain)

If none of the below, please circle: **NONE**

- | | |
|--|--|
| Injuries to the Face, Mouth, Jaw, Chin or Teeth? | Bleeding gums or periodontal problems? |
| Any clicking, popping or pain in the jaw joints? | Do you still have wisdom teeth? |
| Prolonged thumb and/or finger sucking? | Any missing or extra teeth? |
| Do you have any speech problems? | Teeth sensitive to hot and/or cold? |
| Do you have any breathing or airway problems? | Trouble chewing? |

Please explain _____

