RIVERSTONE
—ORTHODONTICS—

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## PATIENT INFORMATION FORM

Date of Exam: _____

Patient's Name: _____
First Middle Last

Date of Birth: _____ Age: _____ Sex: M/F Home Ph: _____

Home Address: _____ Cell Ph: _____
City Zip

Marital Status : ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed

Patient's Dentist: _____ Referred by: _____ Physician: _____

Names and ages of children: _____

Occupation: _____ Business Phone: _____

Employer: _____

Spouse's Name: _____ Business Phone: _____

Occupation: _____ Employer: _____

## MEDICAL HISTORY

Have you ever been treated for any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Diabetes | ☐ | ☐ | Hay Fever | ☐ | ☐ | Hormonal Imbalances | ☐ | ☐ |
| Heart Trouble | ☐ | ☐ | Asthma | ☐ | ☐ | Liver Problems/Hepatitis | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Allergies | ☐ | ☐ | Prolonged Bleeding | ☐ | ☐ |
| Bone Disorders | ☐ | ☐ | Convulsions | ☐ | ☐ | Endocrine/Thyroid | ☐ | ☐ |
| Cancer | ☐ | ☐ | Arthritis | ☐ | ☐ | HIV/AIDS | ☐ | ☐ |
| Kidney Problems | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Cleft Lip or Palate | ☐ | ☐ |

Any other medical concerns? ☐ ☐

List any drugs or medications now being taken and why _____

_____

Are you allergic to any drugs or medications? _____ If yes, list medication _____

Do you wear contact lenses? ☐ ☐

Do you have Glaucoma? ☐ ☐

Are you presently under the care of a physician? _____ If yes, why? _____

Have you taken or are you taking a bisphosphonate bone building drug to treat osteoporosis? ☐ ☐

## DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? ☐ ☐

Do you play a wind musical instrument? _____ If yes, what kind? _____

Do you have speech problems? ☐ ☐

Do you breathe predominantly through the mouth? ☐ ☐

Have you been informed of any missing or extra permanent teeth? ☐ ☐

Have wisdom teeth been removed? _____ If yes, at what age? _____

Have you had any periodontal treatment? ☐ ☐

Do you have frequent head or neck aches ☐ ☐

Have you had any discomfort or clicking in the jaw joints near ears? ☐ ☐

Do you clench or grind your teeth? ☐ ☐

Do you have pain or ringing in the ears? ☐ ☐

Has your jaw ever locked or slipped out of place? ☐ ☐

Are your teeth sore or sensitive? ☐ ☐

When did you last have a checkup/cleaning at the dentist? _____ Any work remaining? ☐ ☐

What is your primary concern? *(Facial appearance, crooked teeth, etc.)* _____

Have you had any previous orthodontic examinations or treatment? _____ If yes, when? _____

Are you especially apprehensive toward dental visits? ☐ ☐

Do you feel that you need orthodontic treatment? ☐ ☐

_____
Signature