ROYAL ORTHODONTICS

ORTHODONTIC SPECIALIST FOR CHILDREN & ADULTS

PATIENT INFORMATION

DATE_____

PATIENT'S NAME _____
LAST FIRST MIDDLE

ADDRESS_____
STREET CITY ZIP

HOME PHONE_____BIRTHDATE_____ SOCIAL SECURITY # _____

IF PATIENT IS A MINOR, GIVE PARENT'S OR GUARDIAN'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

PLEASE LIST SOME INTERESTS OR HOBBIES:_____

RESPONSIBLE PARTY INFORMATION

NAME _____
LAST FIRST MIDDLE

RESIDENCE _____
STREET CITY ZIP

MAILING ADDRESS _____
STREET CITY ZIP

HOW LONG AT THIS ADDRESS?____ HOME PHONE_____ WORK PHONE _____

CELL/OTHER PHONE_____ EMAIL ADDRESS _____

SOCIAL SECURITY #_____ BIRTHDATE_____

RELATIONSHIP TO PATIENT _____

EMPLOYER_____OCCUPATION_____ # YEARS_____

SPOUSE'S NAME_____ RELATIONSHIP TO PATIENT ____

EMPLOYER_____OCCUPATION_____ # YEARS _____

SOCIAL SECURITY #_____BIRTHDATE_____

DENTAL INSURANCE INFORMATION

INSURED'S NAME_____INSURED'S SOCIAL SECURITY # _____

INSURANCE COMPANY_____ GROUP NO._____ LOCAL NO._____

INSURANCE CO. ADDRESS_____PHONE NO. _____

DO YOU HAVE DUAL COVERAGE? YES____ NO____ **IF YES COMPLETE BELOW:**

INSURED'S NAME_____INSURED'S SOCIAL SECURITY # _____

INSURANCE COMPANY_____ GROUP NO._____ LOCAL NO._____

INSURANCE CO. ADDRESS_____PHONE NO. _____

EMERGENCY INFORMATION

NAME OF EMERGENCY CONTACT _____

COMPLETE ADDRESS _____
STREET CITY ZIP

PHONE_____

MAY WE CONTACT THIS PERSON IN CASE OF EMERGENCY? YES☐NO___

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Yes☐ No☐ Are you taking any medication? _____
Yes☐ No☐ Are you allergic to any medication? _____
Yes☐ No☑ Do you have a history of a major illness? _____
Yes☐ No☐ Have you had any operations? _____
Yes☐ No☐ Have you ever been involved in a serious accident? _____
Yes☐ No☐ Have seen a physician in the last 12 months? Why? _____

Circle any medical conditions that you currently or previously have

Abnormal bleeding ☐	Diabetes ☐	Hepatitis/Liver problems ☐
Pneumonia ☐	Anemia ☐	Dizziness ☐
Herpes ☐	Arthritis ☐	Epilepsy ☐
High Blood Pressure ☐	Asthma/Hayfever ☐	HIV/AIDS ☐
Radiation/Chemotherapy ☐	Rheumatic Fever ☐	Gastrointestinal Disorders ☐
Bone Disorders ☐	Heart Problems ☐	Kidney problems ☐
Tuberculosis ☐	Heart Murmur ☐	Nervous Disorders ☐
Congenital Heart Defect ☐	Tumor or Cancer ☐	

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

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

Yes☐ No☐ Are you presently in any dental pain?
Yes☐ No☐ Have you ever had an unfavorable reaction to dentistry?
Yes☐ No☐ Have you ever lost or chipped any teeth?
Yes☐ No☐ Have there been any injuries to face, mouth, or teeth?
Yes☐ No☐ Is any part of your mouth sensitive to temperature/Pressure?
Yes☐ No☐ Do your gums bleed when you brush?
Yes☐ No☐ **Do you have any type of thumb or tongue habit?**
Yes☐ No☐ Are you a mouth breather?
Yes☐ No☐ Have you ever seen an orthodontist? If yes, who/when? _____
Yes☐ No☐ Do you ever have pain in your teeth or jaws when you wake up?
Yes☐ No☐ Are you aware of your jaw clicking or popping?
Yes☐ No☐ Are you aware of clenching/grinding your teeth?
Yes☐ No☐ Do you have "tension" headaches?
Yes☐ No☐ Have you ever experienced chronic ringing in your ears?
Yes☐ No☐ If the patient is **under age 16**, height of parents? Mom____Dad____
Yes☐ No☐ Are you aware that some appts will be during school/work hours?

Female Patients Only:

Yes☐ No☐ Are you pregnant? _____
Yes☐ No☐ Has menstruation started? _____

For Male Adolescent Patients:

Yes☐ No☐ Has voice changed? _____

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Royal to perform a complete orthodontic evaluation.

Signature: _____ Date _____