Patient Information Form

Meadowview Orthodontics, P.A.
4105 West Spring Creek Pkwy, Suite 506, Plano, TX 75024

The information requested below is very important. Please make it as complete and accurate as possible because it will help us provide the best possible health service. This information form becomes part of our permanent records and will be held in strict confidence. For parents of children, complete this form for your child. Please circle YES or NO on the yes and no question. Thank you.

Personal

Name of the patient _____ Date of Birth _____
Age of the patient _____ Gender _____

Family

If patient is a minor, please give the following

1. Name of Father _____ Social Security Number _____
2. Name of Mother _____ Social Security Number _____
3. Are the parent _____ Married ____ Separated _____ Divorced ____ Widowed ____ Remarried

For every patient, please give the following

4. Person responsible for Financial Obligation _____
5. Insurance Company _____
6. Home Address: Street _____
   City _____ State _____ Zip _____
7. Business Name and Address _____
8. Home phone number _____ Business _____
   Cell_____ E mail _____

Dental

1. In your own word, please describe your orthodontic problems
_____
2. Has anyone in your family received orthodontic treatment? YES NO
   If yes, was the patient treated in this office? YES NO
3. By whom were you referred ? _____
4. Your regular dentist's name _____ Address _____
5. When was your last visit to dentist? _____
6. Does the patient have any habit? ___ Lip sucking ____Thumb sucking
   ___Nail biting ____ Mouth breathing ____ Grinding
7. Has the patient had unfavorable experience in a dental or medical office? YES NO
   Describe _____
8. Any injury to teeth (chipped, fractured, ect.) _____
9. Any injury to facial bones _____

Medical

1. Name of the physician _____
2. Address of the physician _____
3. Is the patient taking any medicine currently? _____

4. Was the patient born premature? YES NO
5. Does the patient have any history of allergies? YES NO If yes, please describes
_____
6. Is there a history of any of the following conditions or diseases?

Measles Age _____ Broken bone Age _____ Age _____
Chickenpox Age _____ Serious accidents _____ Age _____
Mumps Age _____ Removal of tonsils and adenoids Age _____
Pneumonia Age _____ German measles Age _____
Scarlet fever Age _____ Whooping cough Age _____

Hearing difficulty _____ Speech difficulty _____
Emotional difficulty _____ Fainting or dizziness _____
Poor vision _____ Liver disease or hepatitis _____
Diabetes _____ Anemia _____
Bleeding problem _____ Birth defect _____
Tuberculosis _____ Heart problem _____
Arthritis _____ HIV _____
Bone and joint problems _____ Sickle cell anemia _____
Kidney disease _____ Cerebral palsy _____
Skin problems _____ Epilepsy or seizures _____
Diseases affecting normal growth _____

7. Female patient only. At what age of the patient did menstruation (menarche) begin?

Social

Name of school _____
Address _____
Name of the school nurse _____
Please check all words which seem best describe the patient:
___ Calm ___ Spoiled ___ Active ___ Cooperative ___ Moody ___Suspicious
___ Fearful ___ Defiant ___ Shy ___ Talkative ___ Compulsive ___ Healthy
___ Sickly ___Temper tantrum ___ Friendly ___ High-strung
Does the patient have any hobby? _____
Is there any other information you believe would be helpful to us? _____
_____

I hereby certify that the above information is accurate and complete to the best of my knowledge. I also grant my permission to the Orthodontist to obtain technical records necessary to plan treatment, and to utilize such records for the purposes of scientific publication.

Date _____ **Signature** _____