Inman & Baldwin Orthodontics

520 N. Miles St. Elizabethtown, KY 42701 (270)769-1349
207 Professional Park Dr. Glasgow, KY (270)651-9386
105 Medical Park Dr. Campbellsville, KY (270)789-4542

Date_____

PATIENT

Patient's Last name_____First name_____ Middle Name_____
Title Mr. Mrs. Ms. Miss. Dr. Other_____Prefers to be called_____
Birth date_____ Age_____ Sex ☐Male ☐Female Social Security #_____
Address_____ City/State_____Zip Code_____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership
Home Phone ( )_____-_____ Email Address_____
Cell Phone ( )_____-_____ Cell Phone Service Provider (i.e. AT&T, Sprint)_____
Would you like to receive appointment reminders? Text- ☐Yes ☐No Email- ☐Yes ☐No
Occupation_____Employer_____
How did you hear about our office?_____

CLOSEST RELATIVE

Spouse or closest relatives name_____
Title Mr. Mrs. Ms. Miss. Dr. Other_____Relationship to patient_____
Address (if different than patient address)_____
Home Phone(If different) ( )_____-_____ Cell Phone ( )_____-_____

DENTIST

Patient's Dentist_____Does patient receive regular dental checkups? ☐yes ☐no
When was patient's last dental exam?_____
How often does patient brush their teeth?_____Is floss used? ☐yes ☐no How often?_____
Other dentists/dental specialists now being seen: Name_____
Reason_____

GENERAL INFORMATION

What are you or your Dentist most concerned about?_____
Describe any previous orthodontic treatment or consultations_____
_____
Have any other family members been treated in our office? Please name them._____
_____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account?_____
Relationship to patient_____
Complete the following if different from previous page:
Address _____
City,State_____ Zip_____
Home phone ( )____-_____ Cell phone ( )____-_____ Email address_____

DENTAL INSURANCE

Primary policy holders full name_____Birth date_____
Social Security #_____ Relationship to patient_____
Address (if not listed above)_____
Insurance company_____Group#_____ID#_____
Insurance company address_____
Insurance company phone ( )____-_____ Policy holders employer_____
Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

Secondary policy holders full name_____Birthdate_____
Social Security #_____ Relationship to patient_____
Address (if not listed above)_____
Insurance company_____Group#_____ID#_____
Insurance company address_____
Insurance company phone ( )____-_____ Policy holders employer_____
Does this policy have orthodontic benefits? ☐Yes ☐No ☐Don't Know

EMERGENCY CONTACT

Name of nearest relative not living with patient_____
Relationship to patient_____ Phone number( )____-_____
Address_____City, State, Zip_____

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HEALTH HISTORY FORM

Patients Name_____ **Birthdate**_____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation. For the following questions , please mark yes, no, or don't know/understand(dk/u).

MEDICAL HISTORY

Now or in the past, has the patient had:

Yes	No	DK/U	
☐	☐	☐	Birth defects or hereditary problems?
☐	☐	☐	Bone fractures or major injuries?
☐	☐	☐	Any injuries to face, head, neck?
☐	☐	☐	Arthritis or joint problems?
☐	☐	☐	Cancer, tumor, radiation treatment or chemotherapy?
☐	☐	☐	Endocrine or thyroid problems?
☐	☐	☐	Diabetes or low sugar?
☐	☐	☐	Immune system problems?
☐	☐	☐	History of osteoporosis?
☐	☐	☐	AIDS or HIV positive?
☐	☐	☐	Seizures, fainting spells, neurological problems?
☐	☐	☐	Mental health disturbance or depression?
☐	☐	☐	History of eating disorder (anorexia, bulimia)?
☐	☐	☐	Frequent headaches or migraines?
☐	☐	☐	High or low blood pressure?
☐	☐	☐	Excessive bleeding or bruising, anemia?
☐	☐	☐	Heart defects, heart murmur, rheumatic heart disease?
☐	☐	☐	Skin disorder (other than common acne)?
☐	☐	☐	Vision or hearing problems?
☐	☐	☐	Frequent ear infections, colds, throat infections?
☐	☐	☐	Asthma, sinus problems, hay fever?
☐	☐	☐	Tonsils and/or Adenoids removed? If removed, what age _____
☐	☐	☐	Does patient frequently breathe through his/her mouth?

Does the patient have any special problems not listed above _____

Has patient had allergies or reactions to any of the following?

Yes	No	DK/U	
☐	☐	☐	Latex (gloves, balloons)
☐	☐	☐	Local anesthetics (novocaine, lidocaine, xylocaine)
☐	☐	☐	Aspirin
☐	☐	☐	Ibuprofen (Motrin, Advil)
☐	☐	☐	Penicillin
☐	☐	☐	Other antibiotics
☐	☐	☐	Metals (jewelry, clothing snaps)
☐	☐	☐	Acrylics
☐	☐	☐	Other substances_____

PATIENT HEALTH INFORMATION

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements, that you take.

Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____
Medication_____ Taken for_____

Has patient ever taken any Bisphosphonates such as Didronel, Skelid, Fosamax, Actonel, Boniva, Aredia, or Zometa for bone disorders or cancer? ☐Yes ☐ No ☐ DK/U If yes, please list_____

Does patient take antibiotic pre-medication before any dental procedures?_____
Does patient have (or ever had) a substance abuse problem?_____
Does patient chew or smoke tobacco?_____
Have you noticed any unusual changes to patients face or jaw?_____
Any other physical problems?_____
Women: Are you pregnant? ☐Yes ☐ No Are you trying to become pregnant? ☐Yes ☐ No

DENTAL HISTORY

Yes	No	DK/U	
☐	☐	☐	Primary(baby) teeth removed that were not loose?
☐	☐	☐	Permanent or extra (supernumerary) teeth removed?
☐	☐	☐	Extra (supernumerary) teeth or missing teeth?
☐	☐	☐	Chipped or injured primary or permanent teeth?
☐	☐	☐	Any sensitive or sore teeth?
☐	☐	☐	Any broken or missing fillings?
☐	☐	☐	Jaw fractures, cysts, infections?
☐	☐	☐	Any teeth treated with root canals or pulpotomies?
☐	☐	☐	Frequent canker sores or cold sores?
☐	☐	☐	History of speech problems or speech therapy?
☐	☐	☐	Difficulty breathing through nose?
☐	☐	☐	Mouth breathing habit or snoring at night?
☐	☐	☐	Frequent oral habits (sucking thumb or finger, chewing pen, etc.)?
☐	☐	☐	Tooth grinding or clenching?
☐	☐	☐	Clicking, locking in jaw joints?
☐	☐	☐	Soreness in jaw muscles or face muscles?
☐	☐	☐	Ringing in ears, difficulty in chewing or opening jaw?
☐	☐	☐	Has patient ever been treated for "TMJ" or "TMD" problems?
☐	☐	☐	Any serious trouble associated with previous dental treatment?
☐	☐	☐	Bleeding gums, bad taste or mouth odor?
☐	☐	☐	Has patient ever been diagnosed with gum disease or pyorrhea?

Have patient's parents or siblings ever had any unusual dental problems?_____
Have patient's parents or siblings ever had any jaw size imbalance?_____

RELEASE AND WAIVER

I authorize release of any information regarding my orthodontic treatment/or my child's orthodontic treatment to my dental and/or medical insurance company.

Patient or Parent/Guardian Signature(if patient is under 18yrs.)_____ Date_____