

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 _____
Prefers to be called _____ Birth date _____ Age _____ Sex ☐ Male ☐ Female
Address _____ City/State _____ Zip Code _____
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
School _____ Sporting Activities/Hobbies _____
How did you hear about our office? _____

PARENT/GUARDIAN

Patient lives with _____
Relationship to patient(Check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather
☐ Grandparents ☐ Other _____
Parent/Guardian's full name _____ Prefers to be called _____
Relationship to Patient ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other _____
Address (If different than patient) _____
Home phone(If different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____
Email _____ Employer _____
Birthdate _____

Parent/Guardian's full name _____ Prefers to be called _____
Relationship to Patient ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Other _____
Address (If different than patient) _____
Home phone(If different) () _____ -- _____ Cell phone () _____ - _____ Work phone () _____ - _____
Email _____ Employer _____
Birthdate _____

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 _____

Brother/sister name _____ age _____ had orthodontic treatment? ☐ yes ☐ no If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ yes ☐ no If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ yes ☐ no If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? ☐ yes ☐ no If yes, where? _____

Have any other family members been treated in this office? Please name them. _____

Emergency contact:

Name of nearest relative not living with patient _____
Relationship to patient _____ Phone number() _____ - _____
Address _____ City, State, Zip _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
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

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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 _____