Stephens & Stephens Orthodontics

Marvin G. Stephens, D.D.S., M.S.D. • Cory K. Stephens, D.D.S., M.S.

Patient Information

Patient Name____ Date____/____/_____
(First) (Mi) (Last) (Nickname)

Address_______________________________ City___________State_____Zip__________

Home Phone #______________Birthdate_____/_____/_____Sex__________Adopted__________

SS#______________School__________________________________Grade_____

Dentist______________________Who Referred You to Us?______________________

Name and age of siblings____

Responsible Party Information

Responsible Party Name____
(First) (Mi) (Last)

Address_______________________________City___________State_____Zip__________

Home Phone #________________Work #________________Cell #________________

Birth Date_____/_____/_____SS#________________Relationship to Pt__________________

Employer______________________How long__________Occupation________________

Spouse/Other Parent's Name____
(First) (Mi) (Last)

Address_______________________________City___________State_____Zip__________

Home Phone #________________Work #________________ Cell #________________

Birth Date_____/_____/_____SS#________________Relationship to Pt__________________

Employer______________________How long__________Occupation________________

Family Information

With whom does the patient live?____

Who should receive routine information about treatment progress?______________________

Who should receive financial information?____________________________________

Who should we contact in case of emergency?____________________Phone______________

I understand that where appropriate, credit bureau reports may be obtained.

Signature______________________Date_____/_____/_____Relationship to Pt______________
(Guardian's signature if patient is a minor)

PLEASE FILL OUT THE OTHER SIDE

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Medical History

Please check Yes or No if the patient has or has ever had…

Y N
[ ] [ ] Joint Pain or Arthritis
[ ] [ ] Bone Disorders
[ ] [ ] Heart Problems
[ ] [ ] Diabetes
[ ] [ ] High Blood Pressure
[ ] [ ] Kidney Problems
[ ] [ ] Rheumatic Fever
[ ] [ ] Hepatitis or Liver Problems
[ ] [ ] Emotional or Psychological Problems
[ ] [ ] Tuberculosis
[ ] [ ] AIDS/HIV
[ ] [ ] Anemia
[ ] [ ] Asthma
[ ] [ ] Epilepsy
[ ] [ ] Prolonged Bleeding
[ ] [ ] Endocrine Problems, Thyroid Problems
[ ] [ ] Tonsils Removed
[ ] [ ] Adenoids Removed

Please list dates and specifics for all "Yes" answers:

____

____

List any allergies, including drugs:___________________

____

List medications currently being taken:______________

____

List any serious illness or operation not listed above:

____

Has a physician ever advised the patient to take antibiotics prior to dental appointments? Y / N

Is the patient currently under a physician's care? Y / N

Physician's Name:________________________________

Reason:____

Dental History

Please check Yes or No if the patient has or has ever had…

Y N
[ ] [ ] Any injury to face, mouth, teeth?
[ ] [ ] Thumb, finger or lip sucking habit (s)?
[ ] [ ] Any speech problems?
[ ] [ ] Mouth breathing when asleep, awake?
[ ] [ ] Snoring?
[ ] [ ] Any known missing permanent teeth?
[ ] [ ] Any known extra permanent teeth?
[ ] [ ] Any teeth removed by extraction? When?
[ ] [ ] Tongue thrust?
[ ] [ ] Any wind instruments played?
[ ] [ ] Clenching or grinding of teeth?
[ ] [ ] Chronically sore or bleeding gums?
[ ] [ ] Jaw pain, popping, grinding, locking?
[ ] [ ] Difficulty chewing or swallowing food?
[ ] [ ] Frequent headaches? If yes, how often?
[ ] [ ] Muscle tenderness or stiffness in neck/jaw?
[ ] [ ] Ringing in ears, dizziness?
[ ] [ ] Previous treatment for TMJ or joint problems?

Please list dates and specifics for all "Yes" answers:

____

____

Does patient visit his/her general dentist regularly? Y / N
Has an Orthodontist been consulted previously? Y / N

Reason:_______________________________________

Has patient experienced a sudden increase in height? Y / N

Does any member of the family or close relative's have a similar arrangement of the teeth or similar appearance of the jaws? Y / N
Explain:_______________________________________

____

List any other dental information known:____________

____

Your chief concern:_____________________________

____

The above information is true to the best of my knowledge, and I understand that it is my obligation to update this information as changes become known to me.

Patient Name____________________________________

Signature___________________________________Date____/____/____Relationship to Pt______________________
(Guardian's signature if patient is a minor)