

Welcome to Young Orthodontics

Andrew N. Young, D.D.S., M.S., P.A.

Patient Information

Patient's Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Birth date _____ SS# _____
How did you hear about our office? _____ Patient's Dentist _____
Has any member of your family previously undergone Orthodontic treatment? _____

Responsible Party Information

Responsible Party's Name _____ Relationship to patient _____
Mailing Address _____ City _____ State _____ Zip _____
How many years at current address? _____ Home Ph. _____ Cell Ph. _____
Previous Address?(if less than 3 yrs.) _____ City _____ State _____ Zip _____
SS# _____ Birth date _____ Drivers License # _____
Employer _____ Work Ph. _____ No. of years _____
Employer address _____ Occupation _____
Email address _____

(Added to your confidential file for optional email confirmations, etc.)

Father/Guardian Name _____ **Check if same as above**
Mailing Address _____ City _____ State _____ Zip _____
Home Ph. _____ Cell Ph. _____ SS# _____ Birth date _____
Employer _____ Work Ph. _____ No. yrs _____
Employer address _____ Occupation _____

Mother/Guardian Name _____ **Check if same as above**
Mailing Address _____ City _____ State _____ Zip _____
Home Ph. _____ Cell Ph. _____ SS# _____ Birth date _____
Employer _____ Work Ph. _____ No. yrs _____
Employer address _____ Occupation _____

Dental Insurance Information

Insured's Name _____ Birth date _____ Insured's SS # _____
Insurance Company _____ Policy # _____ Group # _____
Insurance Company address _____
Insurance Company Phone # _____ Insured's Employer _____

Secondary Insured's Name _____ Birth date _____ Insured's SS # _____
Secondary Insurance Company _____ Policy # _____ Group _____
Secondary Insurance Company address _____
Secondary Company Phone # _____ Insured's Employer _____

Emergency Information

Emergency Contact (other than guardian) _____
Relationship _____ Daytime Ph. _____ Alternative Ph. _____

I certify that all of the above information is true and it is my responsibility to inform this office of any changes, and that when appropriate for financing services received in this office, credit bureau reports may be obtained.

Signature (Guardian's signature if a minor) _____ Date _____
Relationship to the patient _____

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Health History

Initial Date ___/___/___

Update 1 ___/___/___

Update 2 ___/___/___

Medical History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling or Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emotional Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS / HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Tonsils/Adenoids Removed (Please Circle) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco Usage (Cigarettes___Smokeless___) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other_____ |

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

List any allergies: _____

List medications presently being taken: _____

List any serious illness or operation not listed above: _____

Is the Patient currently under a physicians care? _____

Physician's Name _____

Reason _____

Dental History

Please Check Yes or No if the patient has or has ever had...

- | Y | N | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Any injury to face, mouth, teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Thumb, finger or lip sucking habit(s)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any speech problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth breathing when asleep, awake? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known missing permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any known extra permanent teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any teeth removed by extraction? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tongue thrust? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any wind instruments played? |
| <input type="checkbox"/> | <input type="checkbox"/> | Clenching or Grinding of teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronically sore or bleeding gums? |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain, popping, grinding, locking? |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty chewing or swallowing food? |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches? If Yes, how frequent? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle tenderness or stiffness in neck/jaw? |
| <input type="checkbox"/> | <input type="checkbox"/> | ringing of ear, dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Previous treatment for TMJ or joint problems? |

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

Does patient visit his/her dentist regularly? _____

Has an Orthodontist been consulted previously? _____

Reason: _____

Has patient experienced a sudden increase in height? _____

Does any member of the family or close relative(s) have a similar arrangement of the teeth or similar appearance of the jaws?

Explain _____

Please list any other dental information known, and not listed above:

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/Parent/Guardian Signature _____ Date ___/___/___