Updates (date & initial) A B C

Patient Information and Health History

Jaeger Orthodontics

Thank you for completing this form before your first visit.
It is a confidential part of our patient records.

1717 Lincoln Way, Suite 203
Coeur d'Alene, Idaho 83814
(208) 667.3341
(800) 735.1152

Exam Date _____ Exam Time _____ AM PM

JAEGER ORTHODONTICS | braces2school

Patient Information

Patients Name _____ Primary E-Mail _____
Last First Middle Preferred Nickname

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Birthdate _____ Age _____ Sex: ☐ M ☐ F

Social Security # _____ School Name (if applicable) _____ School Grade Level _____

Favorite Subjects _____ Special Interests: hobbies, sports, etc. _____

If the patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name (☐ Same as patient) _____
Last First Middle Marital Status

Residence (☐ Same as patient) _____
Street City State Zip

Mailing Address (☐ Same as above) _____
Street City State Zip

How long at this address _____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. of years employed _____

Spouse's Name _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____ No. of years employed _____

Social Security # _____ Birthdate _____ Relationship to patient _____

Email _____

Insurance Information

Insured's Name _____ Insured's Social Security # _____
Last First Middle

Insurance Company _____ Phone # _____ Insured's date of birth _____

Insurance Company Address _____
Street City State Zip

Do you have dual coverage? ☐ Yes ☐ No If yes:

Insured's Name _____ Insured's Social Security # _____
Last First Middle

Insurance Company _____ Phone # _____ Insured's date of birth _____

Insurance Company Address _____

Insured's Employer _____
Street City State Zip

Emergency Information

Name of nearest relative not living with you _____

Phone Number _____

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

Signature (Parent's or guardian's signature if minor) _____

(continued on back)

Minor Patient Growth Information (if known)

Height of: Patient _____ Father _____ Mother _____

Patient's brothers and sisters:

Name _____ Age _____ Height _____

Name _____ Age _____ Height _____

Name _____ Age _____ Height _____

Has any member of the family had orthodontic treatment? If yes, who and where?

_____

Patient Dental History

Patient's dentist _____

Has your dentist talked to you about an orthodontic concern? ☐ Yes ☐ No

What is your main concern for seeking this appointment? _____

_____

Date of last dental visit for:

Examination _____ X-rays _____

Cleaning _____ Restorative work _____

Has all work been completed? ☐ Yes ☐ No

Check if patient has or has had:

- ☐ Extra teeth
- ☐ Missing teeth
- ☐ Gum disease or infection
- ☐ High rate of tooth decay
- ☐ Teeth sensitive to hot, cold, or sweets
- ☐ Swelling or lumps in the mouth

Check all that apply to patient	Yes	If Yes, please explain
Prior orthodontic evaluation		Date:
Prior orthodontic treatment		Date:
History of thumb or finger sucking		
Play a horn or other mouth instrument		
Breathes with mouth open		
Had a severe injury to the head, face, or teeth		Date:
Treatment for a jaw joint problem		Date:
History of clenching or grinding the teeth		

Does the patient's:	Yes	
Bite feel uncomfortable or unusual		
Jaw joint (TMJ) make noise or hurt when moving		

Does the patient have	Yes	
Pain in or about the teeth, ears, temples, cheeks		
Frequent headaches		

Has the patient:

- Had unusual growth rates ☐ Yes ☐ No
- Reached puberty (generally signalled by voice changing in boys and menstrual cycle in girls) ☐ Yes ☐ No
- Inherited family facial or dental characteristics ☐ Yes ☐ No
- Had a family history of a similar dental condition ☐ Yes ☐ No

Patient Medical History

Patient's doctor _____

Date of last medical exam _____

Check all that apply to patient	Yes	If Yes, please explain
Any health problems or allergies		

Is the patient now:	Yes	
Under a doctor's care		
Taking any medication(s) including bisphosphanates		list:
Mentally or physically challenged		

Has the patient ever:	Yes	
Been under a doctor's care		
Been treated in a hospital		
Taken any medication(s) including biphosphanates		list:
Had an unfavorable reaction to any medication(s)		list:

Please check any of the following which the patient has or has had:

- ☐ Heart disease
- ☐ Rheumatic / Scarlet Fever
- ☐ Heart murmur
- ☐ Bleeding problems
- ☐ Anemia
- ☐ Arthritis
- ☐ Bone disorders
- ☐ Prosthetic joint (replacement)
- ☐ Malignancies, tumors, cancers
- ☐ Liver problems
- ☐ Tuberculosis
- ☐ AIDS or HIV Positive
- ☐ Diabetes
- ☐ Thyroid or hormonal imbalance
- ☐ Kidney problems
- ☐ Asthma
- ☐ Tonsils removed at age _____
- ☐ Adenoids removed at age _____
- ☐ Difficulty breathing through the nose
- ☐ Cleft Lip
- ☐ Cleft Palate
- ☐ Speech Problems
- ☐ Hearing problems
- ☐ Epilepsy
- ☐ Convulsions
- ☐ Fainting
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Wears contact lenses

Are there any other dental or medical concerns we should be aware of?

_____

_____

Signature

This information is complete and accurate. If any information changes, I will notify the Jaeger Orthodontics office immediately

_____ Date

Patient Signature / Guardian signature of minor patient

American Association of Orthodontists