Matthew D. Epperson DMD MSD

Specialist in Orthodontics

WELCOME

DATE _____

PATIENT INFORMATION

NAME (last) _____ (first) _____ (middle) _____

NICKNAME _____ BIRTHDATE _____/_____/_____ AGE _____ SEX: M F

ADDRESS (street) _____

(city) _____ (state)_____ (zip)_____

GENERAL DENTIST _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR OFFICE?

_____

I understand that, in order to be provided with the most flexible payment options, a credit inquiry may be necessary.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

FAMILY INFORMATION

MOTHER'S NAME (last) _____ (first) _____ (m.i.) _____

ADDRESS (street) _____

(city) _____ (state)_____ (zip)_____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYMENT (company) _____ (position)_____

(how long?) _____

SOCIAL SECURITY # _____ – _____ – _____ MARITAL STATUS _____

BEST E-MAIL ADDRESS TO CONTACT RESPONSIBLE PARTY_____

FATHER'S NAME (last) _____ (first) _____ (m.i.) _____

ADDRESS (street) _____

(city) _____ (state)_____ (zip)_____

PHONE (home) _____ (work) _____ (cell) _____

EMPLOYMENT (company) _____ (position)_____

(how long?) _____

SOCIAL SECURITY # _____ – _____ – _____ MARITAL STATUS _____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR PATIENT'S TREATMENT? (please identify only one name)

_____

ORTHODONTIC INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____

ADDRESS _____ PHONE _____

POLICY/GROUP# _____ EMPLOYER_____

INSURED'S NAME _____ SS# _____ – _____ – _____ DOB _____/_____/_____

EMPLOYMENT STATUS ☐ Full time ☐ Part time ☐ Retired

SECONDARY INSURANCE COMPANY _____

ADDRESS _____ PHONE _____

POLICY/GROUP# _____ EMPLOYER_____

INSURED'S NAME _____ SS# _____ – _____ – _____ DOB _____/_____/_____

EMPLOYMENT STATUS ☐ Full time ☐ Part time ☐ Retired

PLEASE COMPLETE THE BACK OF THIS FORM

EMERGENCY INFORMATION

WHOM SHOULD WE CONTACT IN CASE OF AN EMERGENCY?

NAME (last) _____ (first) _____

(phone) _____ (relationship) _____

PATIENT HEALTH HISTORY

DOES (OR DID) THE PATIENT HAVE ANY OF THE FOLLOWING CONDITIONS

YES	NO		YES	NO	
☐	☐	Rheumatic fever	☐	☐	Heart problems
☐	☐	Scarlet fever	☐	☐	Heart murmur
☐	☐	Mitral valve prolapse	☐	☐	High/low blood pressure
☐	☐	Asthma or breathing problems	☐	☐	Kidney problems
☐	☐	Epilepsy or seizures	☐	☐	Tuberculosis (TB)
☐	☐	Hepatitis, jaundice or liver problems	☐	☐	Diabetes
☐	☐	Cleft lip/palate	☐	☐	Endocrine or thyroid problems
☐	☐	Tonsils and/or Adenoids removed	☐	☐	Bone disorders
☐	☐	Speech or hearing problems	☐	☐	Radiation treatment
☐	☐	Anemia or bleeding disorders	☐	☐	Mental health or behavioral problems
☐	☐	Sinus or allergies	☐	☐	HIV/AIDS
☐	☐	Latex Allergy	☐	☐	Sexually transmitted disease

Has the patient ever had any type of surgery? ☐ YES ☐ NO

If "YES," please describe: _____

Is the patient allergic to any medication(s)? ☐ YES ☐ NO

If "YES," please list: _____

Is the patient currently taking any medication (prescription or over-the-counter)? ☐ YES ☐ NO

If "YES," please list: _____

Is the patient under a physician's care for the treatment of a medical condition? ☐YES ☐NO

If "YES," please provide physician's name: _____

Please describe condition: _____

THE FOLLOWING QUESTIONS ARE NECESSARY TO ASSESS YOUR CHILD'S STAGE OF PHYSICAL GROWTH

PATIENT'S HEIGHT _____ WEIGHT _____ INCREASE IN PAST YEAR: HEIGHT _____ WEIGHT _____

GIRLS: Has the patient started her monthly menstrual cycle? ☐ YES ☐ NO If "YES," when? _____/_____/_____

Is there any chance the patient may be pregnant? ☐ YES ☐ NO If "YES," how far along? _____ wks mos

BOYS: Has the patient's voice changed? ☐ YES ☐ NO If "YES," please indicate when: _____/_____/_____

PLEASE CHECK THE APPROPRIATE BOX CONCERNING THE PATIENT'S DENTAL HISTORY

YES	NO		YES	NO	
☐	☐	Trauma to the teeth and/or face	☐	☐	Click or pop of jaw joints
☐	☐	Finger/thumb sucking habit	☐	☐	Jaw pain
☐	☐	Cheek or lip biting	☐	☐	Pain around the ear
☐	☐	Clench or grind teeth	☐	☐	Frequent headaches
☐	☐	Mouth breather	☐	☐	Smoking
☐	☐	Bleeding gums	☐	☐	Aware or concerned about over or under developed jaw?
☐	☐	Sensitive teeth	☐	☐	Are there any family members with similar tooth/jaw relationship?
☐	☐	Frequent cold sores	☐	☐	Is the patient concerned about the appearance of his/her teeth?
☐	☐	Periodontal disease/treatment	☐	☐	Has patient ever been told he/she needs to take antibiotics before dental treatment?

What is your primary concern (why are you here)? _____

How does the patient feel about braces? _____

Has the patient had any previous orthodontic consultation(s) and/or treatment? ☐ YES ☐ NO

If "YES," please explain: _____

Have there been any injuries to the face, mouth, teeth or chin? ☐ YES ☐ NO

If "YES," please explain: _____

Date of last dental visit _____ How often does patient visit dentist? _____

I have read and understand the above questions. The information that I have given is correct to the best of my knowledge. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to this history record or medical/dental status I will inform this practice.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE