2946 Jeremiah Ln NW
Rochester, MN 55901
507-258-5400
866-673-4514
info@rochesterorthodontics.com
www.rochesterorthodontics.com

Patient Information

1. **Please enter PATIENT'S Information:**

First Name: | Middle Initials: | Last Name: | Preferred Name:

Date of Birth: | Gender: | Preferred Pronouns: | Preferred Language:

Address:

Mobile Phone: | Work Phone:

Email: | Preferred Contact Method:

Please list the names of any friends or family currently in the practice:

List any sports, hobbies, or musical instruments played:

Whom may we thank for referring you to our practice?

Preferred T-Shirt Size:

Favorite Color:

Financial Party Information

2. Is the patient also the person who will be financially responsible for treatment?

3. Employer | Occupation | Length of Employment

4. **Please enter PRIMARY RESPONSIBLE PARTY'S information:**

First Name: | Middle Initials: | Last Name: | Preferred Name:

Date of Birth: | Relation to Patient: | Marital Status: | Patient Lives With:

Address (if different than patient):

Mobile Phone: | Work Phone:

Email: | Preferred Contact Method:

Employer: | Occupation: | Length of Employment:

5. Would you like to add a second responsible party?

6. Please enter SECONDARY RESPONSIBLE PARTY'S information:

First Name: | Middle Initials: | Last Name: | Preferred Name:

Date of Birth: | Relation to Patient: | Marital Status: | Patient Lives With:

Address (if different than patient):

Mobile Phone: | Work Phone:

Email: | Preferred Contact Method:

Employer: | Occupation: | Length of Employment:

Responsible party is allowed to have access to the following information. Check all that applies.
☐ Financial Information ☐ Treatment Information ☐ Insurance Only ☐ None

Insurance Information

7. Do you have dental insurance with an orthodontic benefit?

8. Please upload photos of the front and back of your dental insurance card.

9. Primary Insurance

Primary Insurance Company | Member ID or Social Security # | Group #

Patient Relationship to Insured

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Address (if different than patient):

10. Do you have a secondary dental insurance with an orthodontic benefit?

11. **Please upload photos of the front and back of your dental insurance card.**

12. **Secondary Insurance**

Secondary Insurance Company | Member ID or Social Security # | Group #

Patient Relationship to Insured

Insured Name | Insured Phone # | Insured Date of Birth | Insured Gender ○ Female ○ Male

Insured Address (if different than patient):

Dental History

13. Dentist Name:

Check-Up Frequency | Last Dental Visit:

Has the patient had an orthodontic consult or treatment?
○ Yes ○ No

If so, when?

What is the patient's main orthodontic concern?

What's the patient's attitude toward treatment?

14. **Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.**

Speech problems/therapy?
○ No ○ Yes

Clench or Grind Teeth?
○ No ○ Yes

Injury to face, jaw, teeth or mouth?
○ No ○ Yes

Discomfort from teeth or gums?
○ No ○ Yes

Pain, tenderness or noise in either jaw?
○ No ○ Yes

Frequent headaches?
○ No ○ Yes

Oral habits (thumb/finger sucking, lip/nail biting)?
○ No ○ Yes

Neck/shoulder pain?
○ No ○ Yes

Frequent sore throats?
○ No ○ Yes

Brush teeth daily?
○ No ○ Yes

Floss teeth daily?
○ No ○ Yes

Fluoride treatments?
○ No ○ Yes

Mouth breathing?
○ No ○ Yes

Snores during sleep?
○ No ○ Yes

Requires Premedication?
○ No ○ Yes

Any missing or extra permanent teeth?
○ No ○ Yes

Apprehensive about dental care?
○ No ○ Yes

Frequently Chew Gum?
○ No ○ Yes

If any of the above dental questions were answered 'Yes', please explain:

Medical History

15. Date of Last Physical: Physician Name: Patient Health:

Street Address: City: State: Zip Code:

List any medications currently being taken by patient:

List any drug allergies or sensitivities that the patient may have:

16. **Please select YES if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.**

ADHD
○ No ○ Yes

Autism
○ No ○ Yes

Liver Disease
○ No ○ Yes

Kidney Disease
○ No ○ Yes

Epilepsy/Seizures
○ No ○ Yes

Heart Condition
○ No ○ Yes

Stroke
○ No ○ Yes

Respiratory Condition
○ No ○ Yes

Tonsil and/or Adenoid Removal
○ No ○ Yes

Headaches
○ No ○ Yes

HIV/AIDS
○ No ○ Yes

Hepatitis
○ No ○ Yes

Fainting
○ No ○ Yes

Cancer
○ No ○ Yes

Chemotherapy or Radiation Treatment
○ No ○ Yes

Hormone Therapy
○ No ○ Yes

Latex/Metal Allergy
○ No ○ Yes

Abnormal Bleeding
○ No ○ Yes

Diabetes
○ No ○ Yes

Asthma
○ No ○ Yes

Thyroid Problems
○ No ○ Yes

If any of the above medical questions were answered 'Yes', please explain:

_____

_____

17. For Females Only:

Is the patient pregnant?
○ Yes ○ No

Due Date:

_____

Patients Under 18

18. If patient is under the age of 18, please answer the following questions:

Please list the name and birthdate of any siblings:

_____

Height: _____ Weight: _____ School: _____ Grade: _____

Father/Guardian 1 Name: _____ Mother/Guardian 2 Name: _____

Has patient begun puberty:
○ No ○ Yes

If patient is a girl, has menstruation begun:
○ No ○ Yes

If patient is a boy, has their voice changed or have facial hair:

○ No ○ Yes

Has the patient grown in the past year or has their shoe size changed recently:

○ No ○ Yes

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

_____ _____

Signature Date