SOLEIL ORTHODONTICS

Today's Date _____

Patient Information

Patient Name_____ Gender Female
First Middle Last

Address_____
Street City State Zip

Birthdate _____ Email_____

Home Phone _____ Cell Phone _____ Cell Phone Carrier *(for appointment reminders)* T-Mobile

If patient is a minor, give legal guardian's name(s) _____

Siblings and ages _____

Whom may we thank for referring you to our office? Doctor_____ Friend/Family/Other _____

Orthodontic Insurance Information

Policy Holder's Name _____ Social Security #_____ Birthdate _____

Insurance Company Name _____ Employer_____

Insurance Group Number _____ Subscriber ID _____

Secondary Orthodontic Insurance Information

Policy Holder's Name _____ Social Security #_____ Birthdate _____

Insurance Company Name _____ Employer_____

Insurance Group Number _____ Subscriber ID _____

Responsible Party Information

Name_____Marital Status_ Single
Last First Middle

Residence_____
Street City State Zip

How Long at this address_____ Home Phone_____ Work Phone_____

Previous Address *(if less than 3 years)*_____
Street City State Zip

Email Address *(for appointment reminders)* _____

Birthdate_____ Relationship to Patient Spouse

Employer_____ Occupation_____No. Years Employed

Patient Medical History

YES	NO		
☐	☐	1.	Is the patient in good general health at this time?
☐	☐	2.	Is the patient under the care of a physician at this time?
☐	☐	3.	Is the patient taking any medication(s)?
☐	☐	4.	Is the patient allergic to any medications?
☐	☐	5.	Has the patient had tonsils and adenoids removed?
☐	☐	6.	Has the patient ever had serious injuries or been hospitalized?
☐	☐	7.	Does the patient have any special problems not listed?
☐	☐	8.	Has the patient previously taken an antibiotic prior to any dental work?

Patient Dental History

Patient's Dentist_____Date of Last Visit_____

Have there been any injuries to the face, mouth or teeth?
If Yes, please explain_____

Has the patient had (past or present) any of the following habits:

Thumb or finger sucking ☐ Grinding of teeth at night ☐ Mouth Breathing ☐

Has the patient had braces or Invisalign, or been evaluated for orthodontics previously? YES ☐ NO ☐

If Yes, treated/evaluated by Dr. _____

Has the patient ever been evaluated or treated for:

Sleep Apnea / Disordered Breathing ☐ Doctor:
Periodontal Gum Disease ☐ Doctor:
Temperomandibular Joint / Jaw Pain ☐ Doctor:

Does the patient have any speech or hearing problems?
Is the patient concerned or anxious about orthodontic treatment?
Please explain any concerns about the appearance of the teeth and anything you would like to change about the smile:

_____

Has the Patient ever had any of the Following?

(Child and Adult patients)

Yes		Yes	
☐	Craniofacial Condition/Syndrome	☐	Heart Condition
☐	Sleep Apnea	☐	Hepatitis
☐	Breathing Problem	☐	Tuberculosis
☐	Snoring	☐	Aids or H.I.V. Positive
☐	Asthma	☐	Herpes (oral cold-sores)
☐	Allergies	☐	Blood Disorder
☐	Tonsils/Adenoids Removed Jaw	☐	Inflammatory Rheumatism
☐	Clicking/Pain	☐	Arthritis/Juvenile Arthritis
☐	ADHD/ADD	☐	Epilepsy
☐	Developmental Delay Psychiatric	☐	Fainting Spells
☐	Treatment	☐	Stroke
☐	Drug Addiction	☐	Prosthetic (Artificial) Joint
☐	Depression/Emotional Issues	☐	Radiation Therapy
☐	Learning Disability		

OTHER MEDICAL CONDITION:_____

_____

Bisphosphonates

(Adult patients only)

Are you currently taking OR have you *ever* taken a Bisphosphonate (Boniva, Fosamax, Actonel, Aredia, Didronel, Skelid, Zometa) medication, commonly used for Osteoperosis and other conditions that feature bone fragility?

Yes ☐ No ☐

If yes, when did you begin the medication? _____

When did you end the medication? _____

Acknowledgement

Benefits of Orthodontic treatment include aesthetics, health, and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay, decalcification, and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I understand that my diagnostic records and my name may be used for educational purposes. I also understand that orthodontic appointments are often during work and/or school hours. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. Soleil Orthodontics will not be held responsible for any problems arising out of inadequate or undisclosed information. In addition, I authorize Dr. Soleil to perform a complete orthodontic evaluation including xrays as needed.

_____ _____
Signature of Patient or Patient's Legal Guardian, if a minor Date