PATIENT INFORMATION FORM

Instructions: Please provide the information requested down to the solid line. Resident:_____ Chart:_____

Patient

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Birthdate: _____ Age: _____

City: _____ State: _____ Zip: _____ SSN: _____ ☐ M ☐ F

Home Tel: _____ Other Tel: _____ E-Mail: _____

Responsible Party

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Birthdate: _____ Age: _____

City: _____ State: _____ Zip: _____ SSN: _____ Relation: _____

Home Tel: _____ Other Tel: _____ E-Mail: _____

What is the reason for your orthodontic visit? _____

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

Please check your preferred day of appointments: Clinic hours are Monday - Thursday 1:00 - 5:00pm and Friday 8:00 - 12:00 Noon

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ No Preference

Person who has legal custody, if patient is a minor _____

Information Supplied by: _____ _____ _____

Relation to Patient Date

1. Angle Class and Relation of Segments

	Right Side		Left Side	
	Molar	Cuspid	Molar	Cuspid
Class I				
Class II				
Div II				
Class III				

2. Dentition - D = Decay E = Ectopic Eruption X = Missing

8	7	6	e 5	d 4	c 3	b 2	a 1	a 1	b 2	c 3	d 4	e 5	6	7	8
8	7	6	5 e	4 d	3 c	2 b	1 a	1 a	2 b	3 c	4 d	5 e	6	7	8

Examined By:

_____

Doctor

_____

Date

3. Arch Length Mx: ☐ Excess ☐ Adequate ☐ Deficient Amt. _____ mm

Md: ☐ Excess ☐ Adequate ☐ Deficient Amt. _____ mm

4. 3 2 1 | 1 2 3 ☐ Crowded ☐ Even ☐ Spaced Amt. _____ mm

3 2 1 | 1 2 3 ☐ Crowded ☐ Even ☐ Spaced Amt. _____ mm

5. Crossbite: ☐ R ☐ L ☐ Mx Buccal ☐ Mx Lingual

6. Overbite: ☐ Normal ☐ Open Bite ☐ Closed Bite Pct. _____ %

7. Overjet: ☐ X-bite ☐ Edge-2-Edge ☐ Normal ☐ Excessive Amt. _____ mm

8. Curve of Spee: ☐ Deep ☐ Normal ☐ Flat ☐ Reversed

9. Median Line: Mx Midline to Mid-Sagital _____|_____ , Occlusion _____|_____

10. Path of Closure: ☐ Pseudo Cl III ☐ Restrictive ☐ Contact and Mesially ☐ Unrestrictive ☐ Contact and Distally

11. TMJ: ☐ Clicks ☐ Pain ☐ Restricted Mvmnt Opening _____ mm

12. Lip Posture: ☐ Together Relaxed ☐ Together Strained ☐ Apart

13. Lip Muscle Tone: ☐ Hypo ☐ Normal ☐ Hyper

14. Abnormal Frenum: ☐ None ☐ Upper ☐ Lower

15. Tonsils/Adenoids: ☐ None ☐ Normal ☐ Large and a problem

16. Eruption Pattern: ☐ Early ☐ Normal ☐ Late

17. Profile: ☐ Retrusive ☐ Flat ☐ Protrusive ☐ Double Protrusive ☐ Satisfactory

18. Habits: ☐ Tongue Thrust ☐ Frontal ☐ Lateral ☐ Lip Biting ☐ Finger / Thumbsucking ☐ Mouthbreathing ☐ Fingernail Biting ☐ Leaning on Chin or Face ☐ Other _____

19. Oral Hygiene: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

20. Disposition of Case: ☐ Treat Now ☐ Recall in _____ months ☐ No Treatment

21. Type of Treatment: ☐ Phase I ☐ Full ☐ Adult Full ☐ Limited 22. Fee Estimate: _____

Notes:

RESPONSIBLE PARTY / LEGAL GUARDIAN INFORMATION

Responsible Party - Last Name	Responsible Party - First Name	Middle Initial	Marital Status: S M Sep D
Address	City	State	Zip Code
Mailing Address if Different	City	State	Zip Code
Social Security Number / Birth Date	Home Phone ( ) / Work Phone ( )	Relationship to Patient	
Employer	Occupation	# Years Employed	
Address	City	State	Zip Code
Spouse – Last Name	Spouse – First Name	Middle Initial	
Employer	Occupation	# Years Employed	
Social Security Number / Birth Date	Home Phone ( ) / Work Phone ( )	Relationship to Patient	

DENTAL INSURANCE INFORMATION

Insurance Company Name	Insurance Group No.	Insurance Company Phone ( )
Insurance Company Address	City	State / Zip Code
Insured's Name / Birth Date	Relationship to Patient	Insured's SSN
Insured's Employer	Employee Address / City	State / Zip Code
Secondary Insurance Company Name	Insurance Group No.	Insurance Company Phone ( )
Secondary Insurance Company Address	City	State / Zip Code
Insured's Name / Birth Date	Relationship to Patient	Insured's SSN
Insured's Employer	Employee Address / City	State / Zip Code

PERSON TO CONTACT IN CASE OF EMERGENCY

(Nearest relative not living with you)

Last Name	First Name	Relation
Address	City / State / Zip Code	Phone ( )

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

Required Signature _____

(Patient or Legal Guardian / Parent, if patient is a minor)

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School of Dentistry

Name	Date of Birth	Chart #	Page 1

HEALTH HISTORY QUESTIONNAIRE (CONFIDENTIAL)

1. Have you had any health problems in the past five (5) years? ☐Yes ☐No
2. Have you seen a physician or other health care provider in the past two (2) years? ☐Yes ☐No
   Physician's name:_____ Phone # or City:_____
3. Is there any activity your doctor says you cannot do? ☐ Yes ☐No
4. Have you been hospitalized or had a serious illness in the past five (5) years? ☐ Yes ☐No
5. Have you ever had a bleeding problem? ☐Yes ☐No

BASLINE VITAL SIGNS	Temp	Pulse	Resp.	B.P.			
				Date			

Please circle "yes" if you have ever had the following. If you are not sure, do not answer the question.

HEART/BLOOD VESSELS

Rheumatic fever..... Yes No
Rheumatic heart disease..... Yes No
Heart valve damage..... Yes No
Heart murmur..... Yes No
Congenital heart defect..... Yes No
Artificial heart valve..... Yes No
Prolapsed heart valve..... Yes No
High blood pressure..... Yes No
Heart attack (Date_____)..... Yes No
TIA/stroke (Date_____)..... Yes No
Heart Surgery (Date_____)..... Yes No
Vascular Surgery (Date_____).. Yes No
Pacemaker..... Yes No
Coronary heart failure..... Yes No
Congestive heart failure..... Yes No
Angina pectoris/chest pain..... Yes No
Irregular/rapid heart beats..... Yes No
Other heart or vessel disorder..... Yes No

BLOOD

Blood clots or thrombosis..... Yes No
Anemia..... Yes No
Sickle cell disease / trait..... Yes No
Hemophilia..... Yes No
Transfusion (Date_____)..... Yes No
Bruise easily for no apparent reason..... Yes No
Other blood disorder..... Yes No

NERVOUS SYSTEM

Epilepsy..... Yes No
Seizure disorder..... Yes No
Multiple sclerosis..... Yes No
Trigeminal neuralgia..... Yes No
Chronic pain..... Yes No
Anxiety/depression..... Yes No
Alzheimer's disease/dementia..... Yes No
Psychiatric treatment..... Yes No
Psychological counseling..... Yes No.
Persistent dizziness/fainting spells..... Yes No
Persistent numbness/tingling..... Yes No
Other nervous system/mental disorder..... Yes No

HEAD AND NECK

Glaucoma..... Yes No
Chronic sinusitis..... Yes No
Injury to head, neck, jaw or teeth..... Yes No
Headaches..... Yes No
Unexplained visual change..... Yes No
Frequent or severe nosebleeds..... Yes No
Persistent sore throat or hoarseness..... Yes No
Recurrent neckache or neck pain..... Yes No
Recent difficulty swallowing..... Yes No
Other head or neck disorder..... Yes No

ENDOCRINE

Diabetes..... Yes No
Low thyroid..... Yes No
Other thyroid condition..... Yes No
Cushings syndrome..... Yes No
Parathyroid condition..... Yes No
Other endocrine condition..... Yes No

MUSCULOSKELETAL / CONNECTIVE TISSUE

Sjogren's syndrome..... Yes No
Arthritis..... Yes No
Artificial joint (Date_____)..... Yes No
Fibromyalgia/rheumatism..... Yes No
Chronic back pain..... Yes No
Other muscle or bone disorder..... Yes No

RESPIRATORY

Tuberculosis (TB)..... Yes No
Asthma..... Yes No
Chronic bronchitis..... Yes No
Emphysema..... Yes No
Persistent cough..... Yes No
Cough up bloody sputum..... Yes No
Shortness of breath..... Yes No
Other respiratory disorder..... Yes No

URINARY TRACT

Kidney disease..... Yes No
Renal dialysis..... Yes No
Venereal disease..... Yes No
Sexually transmitted disease..... Yes No
Other urinary disorder..... Yes No

DIGESTIVE SYSTEM

Hepatitis..... Yes No
Cirrhosis of the liver / liver disease..... Yes No
Ulcers..... Yes No
Jaundice..... Yes No
Frequent heartburn or reflux..... Yes No
Frequent nausea/vomiting..... Yes No
Other digestive disorder..... Yes No

CANCER HISTORY

Cancer..... Yes No
If yes, what type_____
Leukemia..... Yes No
Benign tumors/growths..... Yes No
Type of treatment:
Surgery..... Yes No
Radiation therapy..... Yes No
Chemotherapy..... Yes No
Hormone therapy..... Yes No

ALLERGY HISTORY

Are you allergic to or have you ever had a Bad reaction to any of the following?
Dental anesthetics..... Yes No
Penicillin..... Yes No
Sulfa drugs..... Yes No
Other antibiotics..... Yes No
Aspirin..... Yes No
Latex products..... Yes No
Metals, including jewelry..... Yes No
Other allergy..... Yes No

FAMILY HISTORY

Has anyone in your family (grandparent, parent, sibling, child) ever had:
Diabetes..... Yes No
Heart disease..... Yes No
Depression or anxiety..... Yes No
Tuberculosis..... Yes No
Any disorder that "runs in" Your family..... Yes No

PLEASE CONTINUE ON OTHER SIDE

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HEALTH HISTORY QUESTIONNAIRE (continued)

Please circle "yes" if you have ever had the following. If you are not sure, do not answer the question.

MISCELLANEOUS

Lupus erythematosus..... Yes No
Organ transplant.....Yes No
If yes, which organ?_____
Suppressed immune system..... Yes No
Persistent fever..... Yes No
Taken steroid/prednisone..... Yes No
Tested positive for HIV..... Yes No
Been diagnosed with AIDS.....Yes No
Taken prescription diet pills..... Yes No
If yes, please check type:
☐ Pondimin ☐ Phen-fen
☐ Redux ☐ Other_____

MISCELLANEOUS (CONTINUED)

Used tobacco products..... Yes No
If yes, what type?_____
How much?_____ How long?_____
Still using tobacco?..... Yes No
Would you like to quit?.....Yes No
Quit on? (Date_____)
Drink alcoholic beverages..... Yes No
If yes, how much?_____
Used methamphetamine, amphetamines or "speed"..... Yes No
Used intravenous drugs..... Yes No
Used cocaine or "crack"..... Yes No

MISCELLANEOUS (CONTINUED)

Used any other recreational drug... Yes No
Are you a recovering alcoholic or addict?..... Yes No

WOMEN ONLY

Are you pregnant or is there a possibility that you may be pregnant?... Yes No
If yes, due date_____
Are you breast feeding?..... Yes No
Are you in or have you passed through Menopause (change of life)?..Yes No

Do you have any other condition that you think we should know about? ☐ Yes ☐ No _____

_____

Please circle all the medications you are currently taking:

Heart	Blood thinners	Hormones	Antibiotics	Tranquilzers
Nitroglycerin	Blood pressure	Insulin/diabetic drugs	Antihistamine	Antidepressants
Digitalis	Oral contraceptive	Thyroid	Cyclosporine A	Pain
Aspirin (____tabs/day)	Steroids/Cortisone	Nifedipine		

List medication names and dosages (include over-the-counter, herbal and nutritional supplements):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of # of Reviewing Faculty Date

HEALTH UPDATES *[Required at least every six (6) months; more often as indicated]*

Date	Note changes below	Patient Signature	Faculty Review	Faculty #
	INITIAL REVIEW BY FACULTY			

Note: A new Health History Questionnaire should be completed at least every two (2) years; more often if indicated or if all Health Update space above have been used.

LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL
SLEEP DISORDERS CENTER

Please answer the following questions about your child's sleep, when he/she DOES NOT HAVE A COLD.
On a scale of 1 to 10:

1 2 3 4 5 6 7 8 9 10
NEVER SOMETIMES ALWAYS

To what extent does your child have:

(1) Difficulty breathing
1 2 3 4 5 6 7 8 9 10

(2) Snoring or noisy breathing
1 2 3 4 5 6 7 8 9 10

(3) Observed times with no breathing
1 2 3 4 5 6 7 8 9 10

(4) Irritability (fussy)
1 2 3 4 5 6 7 8 9 10

(5) Sleepiness during the day of excessive napping
1 2 3 4 5 6 7 8 9 10

(6) Poorer school performance than expected
1 2 3 4 5 6 7 8 9 10

(7) Restlessness, tossing, turning
1 2 3 4 5 6 7 8 9 10

(8) Mouth breathes while awake
1 2 3 4 5 6 7 8 9 10

(9) Tonsil infections or sore throats
1 2 3 4 5 6 7 8 9 10

(10) Sweating during sleep
1 2 3 4 5 6 7 8 9 10

(11) Gasps for air during sleep
1 2 3 4 5 6 7 8 9 10

(12) Choking during sleep
1 2 3 4 5 6 7 8 9 10

(13) Turns pale or blue
1 2 3 4 5 6 7 8 9 10

PATIENT'S NAME_____ DATE_____

GENDER_____ AGE_____