**Shannon Simons, D.D.S.**
*Specialist in Orthodontics*
*Children and Adults*
A PROFESSIONAL DENTAL CORPORATION

**Date:** _____

## Patient Information

Patient's Name: _____ Prefers to be Called: _____
First Middle Last

Address: _____
Street City State Zip

Patient's Cell Phone: _____ Birthdate: _____ Age: _____ Sex: M / F

If patient is a minor, give parents' or guardian's name: _____

School: _____ Grade: _____

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

Siblings/Children Yes/No Name/Age _____ Name/Age _____ Name/Age _____

## Responsible Party Information

Name: _____ Marital Status: _____
First Middle Last

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Email address: _____ Cell Phone: _____ Work Phone: _____

Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. Years Employed: _____

Spouse's Name: _____ Birthdate: _____
First Middle Last

Spouse's Employer: _____

No. Years Employed: _____ Occupation: _____ Cell Phone: _____

## Dental Insurance Information

Insured's Name: _____ Subscriber ID # or SSN #: _____

Insured's Employer: _____

Insurance Company: _____ Group No.: _____

Insurance Co. Address: _____ Phone: _____

Do you have dual coverage? ☐ Yes ☐ No

## Previous Orthodontist Information

If transferred, name of previous orthodontist: _____
Address: _____
Phone: _____

## Emergency Information

Name of person to contact in case of an emergency: _____

Phone: _____ Relationship: _____

**Confidential**

***Over***

## Medical History

Primary Care Physician: _____ Date of Last Visit: _____

*Please circle Yes or No (if Yes, please fill in details)*

YES NO Are you taking any medications? _____
YES NO Are you allergic to any medications? _____
YES NO Do you have a history of major illness? _____
YES NO Have you had any major operations? _____
YES NO Have you ever been involved in a serious accident? _____
YES NO Do you require an antibiotic prior to dental cleanings? _____

*Circle any of the medical conditions below that you have had or currently have*.

| | | | |
|---|---|---|---|
| AIDS/HIV | Anemia | Arthritis | Asthma or Hayfever |
| Bone Disorders | Diabetes | Dizziness | Epilepsy |
| Hepatitis | Herpes | High Blood Pressure | Gastrointestinal Disorders |
| Heart Problems | Kidney Disorder | Liver Disorder | Nervous disorder |
| Pneumonia | Rheumatic Fever | Tuberculosis | Tumor or Cancer |
| Prolonged Bleeding | | | |

Are there any medical conditions we have not discussed that you feel we should be aware of? YES NO
If child, have you reached puberty? Girls-have you started menstruation: _____ Boys-has your voice changed: _____
Is your child adopted? YES NO

## Dental History

Dentist: _____ Date of Last Visit: _____
Address: _____ Phone: _____

What concerns you most about your teeth? _____

_____

YES NO Are you in any pain or discomfort? _____
YES NO Have you ever experienced any unfavorable reaction to dentistry? _____
YES NO Have you ever lost or chipped any teeth? _____
YES NO Have there been any injuries to face, mouth or teeth? _____
YES NO Is any part of your mouth sensitive to temperature or pressure? _____
YES NO Do your gums bleed when you brush? _____
YES NO Do you have any type of thumb or tongue habit? _____
YES NO Are you a mouth breather? _____
YES NO Have you ever seen an orthodontist? _____
YES NO Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
YES NO Do you have any pain or soreness around your face, neck or back? _____
YES NO Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____
YES NO Are you aware of your jaw clicking or popping? _____
YES NO Are you aware of clenching your teeth during the day? _____
YES NO Have you ever been told that you grind your teeth? _____
YES NO Do you have “tension” headaches? _____
YES NO Are you aware that some appointments will be during school/work hours? _____

## Benefits of Orthodontic Treatment

*Esthetics, Health and Function*

Orthodontics is a service that provides improvements 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 and enlarged gums may 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 hereby certify that I have reviewed the above health history and that it is accurate to my knowledge at this time. If there are any future changes in this information, I will inform the office of these changes. This information is for our records and is confidential.**

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

_____ _____
Patient/Parent Signature Date