



Jeffrey G. Johnson, DDS, MS, PA

Orthodontic Excellence for Children & Adults

DATE _____ PATIENT'S SCHOOL: _____

PATIENT INFORMATION

EMAIL: _____

PATIENT'S FULL NAME _____
FIRST MIDDLE LAST NICKNAME

ADDRESS _____
STREET CITY ZIP CODE

PATIENTS' BIRTHDATE _____ AGE _____ MALE _____ FEMALE _____ SINGLE _____ MARRIED _____
MONTH DAY YEAR

PATIENT'S DENTIST _____ WHO REFERRED YOU? _____
FIRST LAST FIRST LAST

HAS ANY MEMBER OF YOUR FAMILY UNDERGONE ORTHODONTIC TREATMENT? _____

NAME AND AGES OF CHILDREN OR SIBLINGS? _____

RESPONSIBLE PARTY INFORMATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET CITY STATE ZIP CODE

HOME PHONE () _____ CELL PHONE () _____

SOCIAL SECURITY # _____ BIRTHDATE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ OCCUPATION _____

ORTHODONTIC INSURANCE INFORMATION

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ EMPLOYER PHONE # _____

SOCIAL SECURITY # _____ BIRTHDATE _____

INSURANCE COMPANY NAME & ADDRESS _____
INSURANCE COMPANY ADDRESS CITY/ST ZIP

GROUP # _____ INSURANCE COMPANY PHONE () _____

HEALTH HISTORY

Is patient currently under physician's care? _____ Reason _____

Please check if patient has or has had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Adenoids removed | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Ear problems | <input type="checkbox"/> HTLV-III virus | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney treatment | <input type="checkbox"/> TMJ disorders |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Faintness/Dizziness | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches(frequent) | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsils removed |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Prolonged bleeding | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer treatment | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Congenital heart lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scoliosis | |

Please check if answer is YES to any of the following questions?

- | | | |
|--|---|--|
| <input type="checkbox"/> Any injuries to face, mouth, teeth? | <input type="checkbox"/> Thumb, finger, or lip sucking? | <input type="checkbox"/> Mouth-breathing when asleep or awake? |
| <input type="checkbox"/> Any missing permanent teeth? | <input type="checkbox"/> Any extra permanent teeth? | <input type="checkbox"/> Any teeth removed previously by extraction? |
| <input type="checkbox"/> Is there a tongue-thrust problem? | <input type="checkbox"/> Any speech problems? | <input type="checkbox"/> Any pain or clicking on opening mouth? |
| <input type="checkbox"/> Any bruxing (grinding of teeth)? | <input type="checkbox"/> Has an orthodontist been consulted previously? | |

List any other serious illnesses:

List any allergies:

What would you like to have orthodontic treatment accomplish for you? _____