guidry orthodontics

Patient Information

Today's Date _____ ☐ Male ☐ Female

Name _____
Last First MI

Date of Birth _____ Age _____ Common Name _____

Address _____
Street City/State/Zip

Home # _____ Cell # _____ E-mail _____

School _____ Patient's Hobbies/Interests_____

Responsible Party Information

Name _____ Relationship to Patient _____
Last First MI

Employer _____ Occupation _____

Home # _____ Cell # _____ E-mail _____

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Spouse/Other _____ Relationship to Patient _____

Home # _____ Cell # _____ E-mail _____

Family members previously treated here _____

How did you hear about our office? _____

Medical/Dental History

General Dentist _____ Last Visit _____

Is the patient under the care of a physician for a specific problem at this time?

_____

Physician's Name _____

Taking any prescription medication? ☐ Yes ☐ No If so, which ones?_____

Are you currently taking a bisphosphonate for osteoporosis?

☐ Yes ☐ No ☐ Fosamax ☐ Boniva ☐ Actonel ☐ Other _____

List any drug sensitivities _____

Please check all of the following that apply

☐ Asthma ☐ Jaw Joint Pain ☐ Teeth Grinding

☐ Diabetes ☐ Bone Disorders ☐ Heart Condition

☐ Epilepsy ☐ ADD/ADHD ☐ Kidney Problems

☐ Hepatitis ☐ AIDS/HIV ☐ Endocrine Problems

Have you been informed of any missing/extra teeth? ☐ Yes ☐ No

Has an orthodontist previously been consulted? ☐ Yes ☐ No

Has he/she had any previous orthodontic treatment? ☐ Yes ☐ No

Adolescent patients only

Has the patient reached puberty? ☐ Yes ☐ No

Girl: Has she started menstruation? ☐ Yes ☐ No Month/Yr _____

Boy: Has his voice changed? ☐ Yes ☐ No

_____ _____

Signature of Patient/Parent/Guardian Date