JEFFREY D. BACKUS, D.M.D.
Practice Limited to Orthodontics
Member, AMERICAN ASSOCIATION OF ORTHODONTICS

ORTHODONTIC PATIENT INFORMATION

Date____________________Family Dentist_____________________________Referred by_______________________

PATIENT INFORMATION
Name____
First Middle Last Nickname
Address____
Street City Zip Code
Phone #s: _______________(H)_______________(W) Age_______Birthdate_____________________Sex________
Month/Day/Year
Primary E-mail address: ____
In case of an emergency? Name_______________________________________ Phone_________________________
School____ Grade_________________________
Person Financially Responsible for Treatment___________________________________Relationship______________
Relative who is a patient____

IF PATIENT IS MINOR:
Father
First Name____SSN____________________Birthdate__________
Address____Home Phone________________
Employer____Occupation__________________
Bus. Address____Bus. Phone__________________
Mother
First Name____SSN__________________Birthdate__________
Address____Home Phone_________________
Employer____Occupation__________________
Bus. Address____Bus. Phone__________________

Primary E-mail address: ____

IF PATIENT IS AN ADULT:

Employer____Occupation___________________
Bus. Address____SSN__________________________
If married, please provide the following information:
Name of Spouse____SSN_________________________
Employer____Occupation___________________
Bus. Address____Bus. Phone___________________

May we discuss patient's treatment (i.e. appointment times, treatment progress, and health information) with other family members and friends in accordance with the Health Information Privacy Policy Act (HIPPA)?
Yes_____No_____

Continue on back →

MEDICAL HISTORY

Physician's Name____Date of last Physical Exam ____________

PLEASE INDICATE ANY OF THE FOLLOWING WHICH APPLY TO THE PATIENT

( ) Anemia/Blood Problems
( ) Blood Disease
( ) Hepatitis/Liver Problems
( ) Jaundice
( ) Heart Disease
( ) High Blood Pressure
( ) Tuberculosis
( ) Diabetes
( ) Endocrine Problems
( ) Bone Disorders
( ) Epilepsy
( ) Thyroid Disorder
( ) Drug Allergies (list below)
( ) Oral Herpes
( ) Tonsillitis
( ) Tonsils / Adenoids Removed?
( ) Asthma
( ) Venereal Disease
( ) Allergies
( ) Radiation Treatment
( ) Ulcer / Colitis
( ) Rheumatic Fever
( ) Excessive Bleeding From Cuts or Extractions
( ) Psychiatric Care/Emotional Problems
( ) Pregnancy? If so, what month______________

DESCRIBE ANY CURRENT MEDICAL TREAMENT INCLUDING DRUGS TAKEN NOT LISTED ABOVE:

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IF PATIENT IS A MINOR:

Father's Height_________Mother's Height________Patient Resembles ( ) Father ( ) Mother ( ) Neither Parent

Patients Height_________ Weight________ Increase in Past Year: Height ____________Weight____________

Girls: Has menstruation begun ( ) Y ( ) N When? _________________________

Has patient shown other signs of pubertal development? ( ) Y ( ) N

Boys: Has voice changed? ( ) Y ( ) N When? ____________________________

Has patient shown other signs of pubertal development? ( ) Y ( ) N

DENTAL HISTORY

PLEASE INDICATE ANY OF THE FOLLOWING WHICH APPLY TO THE PATIENT:

( ) Head /Face injuries
( ) Speech Problems
( ) Thumb/Finger Habit
( ) Dental Injuries
( ) Difficult Oral Surgery
( ) Frequent Cold Sores
( ) Periodontal Treatment
( ) Clenching/Grinding
( ) Click/Pop of Jaw Joint
( ) Pain Around Ear
( ) Bleeding Gums
( ) Sensitive Teeth
( ) Missing/Extra Permanent Teeth
( ) Tobacco Use

Is patient concerned about the appearance of his/her teeth? ( ) Y ( ) N
Does the patient play a musical instrument? ( ) Y ( ) N
Has the patient had previous orthodontic treatment/consultation? ( ) Y ( ) N
Are you aware that some appointment will infringe on school and/or work time? ( ) Y ( ) N

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PATIENT / PARENT / GUARDIAN Date

OFFICE USE ONLY:____