HOUSTON
281.392.1155
909 Dairy Ashford Rd, Suite 107
Houston, TX 77079
info@lairdortho.com

KATY
281.392.1155
23150 Westheimer Pkwy
Katy, TX 77494
info@lairdortho.com

Orthodontic Patient Information and Health History Form

Patient Information

Patient Name _____ (LAST / FIRST / M.I.)

Nickname _____

Date of Birth _____ Age _____

Home Address _____

City _____ State _____ Zip _____

Social Security# _____ Sex _____

Cell Phone _____

E-mail Address _____

Adult Patients

Martial Status ☐ Single ☐ Married ☐ Widowed ☐ Separated

Employer _____

Work Phone _____ Occupation _____

Patients Under 18

Lives with ☐ Mother ☐ Father ☐ Both ☐ Other _____

School _____ Year of HS Grad _____

Interests and Hobbies _____

Account Information

Person Responsible for the Account

Name _____ (LAST / FIRST / M.I.)

Relation to Patient _____

Billing Address _____

City _____ State _____ Zip _____

Social Security# _____ D.O.B. _____

Cell Phone _____ Work Phone _____

Additional Information

Has the pt had a previous ortho consultation? ☐ Yes ☐ No

Has the pt had previous orthodontic treatment? ☐ Yes ☐ No

Is the patient comfortable going to the dentist? ☐ Yes ☐ No

How many times per day does pt. brush? _____

Chief orthodontic concern? _____

_____

Dental Insurance Information

Primary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Subscriber Employer _____

Group# _____ Subscriber ID# _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child

Secondary Insurance

Insurance Company _____

Subscriber Name _____

Subscriber D.O.B. _____

Subscriber Employer _____

Group# _____ Subscriber ID# _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child

Dentist and Physician Information

Former or Current Dentist _____

Address/Clinic Location _____

City _____ State _____ Zip _____

Phone _____ Last visit _____

Family Physician _____

Address/Clinic Location _____

City _____ State _____ Zip _____

Phone _____ Last visit _____

Does the patient have?

Difficulty in opening, chewing or swallowing? ☐ Yes ☐ No

Pain or clicking in jaw joint? ☐ Yes ☐ No

Pain on chewing, yawning or wide opening? ☐ Yes ☐ No

Pain in or about the ears or cheeks? ☐ Yes ☐ No

A jaw that 'locks', 'gets stuck' or feels unusual? ☐ Yes ☐ No

Noises in or from the jaw joints? ☐ Yes ☐ No

Dental History

Has the patient ever had:

Yes	No	
☐	☐	Injury to head or neck
☐	☐	Injury to face, jaw, teeth, or gums
☐	☐	Discomfort from teeth or gums
☐	☐	Teeth sensitive to hot or cold
☐	☐	Avoid chewing on one side
☐	☐	Oral surgery
☐	☐	Bleeding gums
☐	☐	Gum treatment
☐	☐	Fluoride treatment
☐	☐	Mouth breathing
☐	☐	Grind or clench teeth
☐	☐	Pain, tenderness, noise in either jaw
☐	☐	Frequent headaches
☐	☐	Neck / shoulder pain
☐	☐	Splint therapy
☐	☐	Oral habits (thumb / finger / lip / nails)
☐	☐	Abnormal swallowing (tongue thrust)
☐	☐	Speech problems / therapy
☐	☐	Frequent sore throats
☐	☐	Frequent gum chewing

Medical History

Has the patient ever had:

Yes	No	
☐	☐	ADD / ADHD
☐	☐	Arthritis
☐	☐	Asthma / Breathing Difficulties
☐	☐	Autism / Asperger's / PPD - NOS
☐	☐	Bleeding Disorders
☐	☐	Birth / Congenital Defects
☐	☐	Cancer
☐	☐	Cold Sores
☐	☐	Diabetes
☐	☐	Endocrine Problems
☐	☐	Emotional Problems
☐	☐	Allergies to latex, metal, drug, food, etc.
☐	☐	Epilepsy / Seizure
☐	☐	Headaches / Migraines
☐	☐	Hepatitis
☐	☐	Herpes
☐	☐	HIV / AIDS
☐	☐	Oral Ulcers
☐	☐	Osteoporosis / Osteopenia
☐	☐	Previous Surgery
☐	☐	Thyroid Problems

If yes to any of the above, please give details: _____

_____

Thank you for coming in!

Which of these best describes how you found Laird Ortho?

☐ Referred by a friend or family member

_____

Please let us know who so we may send them a thank you card.

☐ Referred by my insurance provider / website

☐ Drove by your office / close to me

☐ Google / online search

☐ Referred by your dentist _____

☐ Community event _____

☐ Other _____

Medications

Medication		Reason	

Are there any medications that have been prescribed but not taken? ☐ Yes ☐ No

Does the pt need to pre-medicate / take an antibiotic prior to dental procedures? ☐ Yes ☐ No

Have the pt ever taken Bisphosphonates? ☐ Yes ☐ No

Authorization

I authorize release of any information regarding my or my child's orthodontic treatment to my dental and/or medical insurance company. I have read the above questions and understand them. To my knowledge, the above information is correct. If there are any changes in this medical history, I will inform the Laird Orthodontics.

_____ _____

Print Name Orthodontist Signature

_____ _____

Patient / Guardian Signature Date