DR. JACK "CHIP" CASE JR., DDS, MS, PLLC
Diplomate American Board of Orthodontics

PATIENT INFORMATION

In order to perform an evaluation of your orthodontic needs or to provide treatment, the following information front and back is necessary.

PATIENT #______________________ *(Office Use Only)* DATE: ____________________________

Patient Name: ______________________________________Sex: M___ F___ Preferred Name: ___________________
Address: ____
Street City State Zip
Home Phone: _____________________ Cell Phone: ______________________ Work Phone ____________________
Birthdate: ______________ Age: ______ SSN: ___________________General Dentist: _________________________
Email: ____ Do you have dental Insurance? _________________________
Martial Status: _______________________ Special Interests: ____
Name of School you attend: __________________________ Occupation:___________________________________
Whom may we thank for referring you to our office? Dentist_______________ Patient/Friend______________
Has any member of your family or a friend been seen or treated in this practice ________________________

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS UNDER 18)

Fathers Name: ______________________________ Mothers Name: ______________________________
Address: ___________________________________ Address: ___________________________________
City: ______________ State: _________ Zip: ________ City: ______________ State: _________ Zip: ________
Employer: ________________ Phone#_____________ Employer: _______________ Phone #______________
Occupation: ___________________________________ Occupation: ___________________________________
Email: ____ Email: ____
SSN: _______________________ DOB_____________ SSN: _______________________ DOB_____________
Martial Status: _______________________ Martial Status: _______________________
Does child live with both parents? ____
If parents are divorced, please list other parent's names: ____

Emergency Contact: ______________________________ Phone: ______________________________
Address: ____

I agree that all the above information is correct.
I understand that where appropriate, credit bureau reports may be obtained.

Patients Signature: ____________________________ Date: ______________________________
Parent/Guardian Signature: ____________________________ Date: ______________________________

Please turn page over for medical history

MEDICAL HISTORY

Patients Physician Name: __________________________ Please circle the following:

Are you in good health? **Yes** **No** If no, explain:____

Do you have history of major illness or hospitalization? **Yes** **No** If yes, explain: _________________________________

Are you currently under the care of a physician? **Yes** **No**

Do you currently take any medication? **Yes** **No** If yes, what? ______________________________________

Are you **allergic/sensitive to any medications or latex**? **Yes** **No** If yes, what?_______________________________

Do you frequently get colds? **Yes** **No** Sore throat? **Yes** **No** Ear infections? **Yes** **No**

Have you had your tonsils removed? **Yes** **No** If yes, when? ______________________________________

Did you have a blood transfusion prior to March 1985? **Yes** **No** If yes, have you been tested for HIV/AIDS since then?

Do you currently have or have had any of the conditions listed below? Please **circle** appropriate response:

Yes	**No**	Heart Attack	**Yes**	**No**	Bleeding Disorder	**Yes**	**No**	Asthma
Yes	**No**	Heart Murmur	**Yes**	**No**	Hepatitis	**Yes**	**No**	Herpes
Yes	**No**	Rheumatic Fever	**Yes**	**No**	HIV/AIDS	**Yes**	**No**	Kidney Disorders
Yes	**No**	Congenital Heart Defect	**Yes**	**No**	Diabetes	**Yes**	**No**	Epilepsy
Yes	**No**	Stroke	**Yes**	**No**	Leukemia	**Yes**	**No**	Fainting/Dizzy
Yes	**No**	Mononucleosis	**Yes**	**No**	Bone Disorders	**Yes**	**No**	Endocrine Disorders
Yes	**No**	Rheumatic Heart Disease	**Yes**	**No**	Tuberculosis	**Yes**	**No**	Anemia

Has the patient reached puberty? **Yes** **No**

Patients Height: ____________ Weight: ____________

DENTAL HISTORY

Dentist Name: ________________ Oral Surgeons Name: ________________

When was your last dental exam/cleaning? ___________________________

Do you have extra teeth? **Yes** **No** Missing teeth? **Yes** **No** Loose teeth? **Yes** **No** Sensitive teeth? **Yes** **No**

Have you ever had any injuries to your face, mouth, or teeth? **Yes** **No** If yes, explain: ____________________________

Have you ever sucked your thumb or fingers? **Yes** **No** If yes, explain: ____________________________

Do you have any speech problems? **Yes** **No** If yes, explain: ____________________________

Are you a mouth breather while awake? **Yes** **No** While asleep? **Yes** **No**

Do you have clicking, popping, or pain in your jaw joint? (TMJ) **Yes** **No** If yes, explain: ___________________________

Do you clench or grind your teeth? **Yes** **No** If yes, explain: ______________________________________

Do you suffer from frequent headaches? **Yes** **No**

Does your jaw ever hurt? **Yes** **No** If yes, explain: ______________________________________

Has either parent had orthodontic treatment? **Yes** **No**

Have you ever had an orthodontic evaluation before today? **Yes** **No** If yes, by Whom: _____________________________

In your own words, please tell us why you are interested in orthodontic treatment: _______________________________

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The information given about my health history in this form is accurate and complete to the best of my knowledge. I hereby give consent to perform necessary diagnostic tests, including x-rays & photographs, and to evaluate my dental health. Signature of patient, parent, or guardian: ____________________________________ Date:__________________