

**prairie**ridge  
ORTHODONTICS  
JEFF LOVELESS DDS MS

Name: \_\_\_\_\_

Nickname: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Responsible: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Patient Lives With: \_\_\_\_\_

Mother's Home Phone: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_

Mother's Cell Phone: \_\_\_\_\_

B-Day: \_\_\_\_\_

Gender: \_\_\_\_\_

Activities: \_\_\_\_\_

Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Is your dentist recommending any dental work at this time? \_\_\_\_\_

Whom may we thank for referral to our practice:

\_\_\_\_\_

\_\_\_\_\_

E-mail Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Who is with the Child Today: \_\_\_\_\_

Father's Home Phone: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_

## MEDICAL AND DENTAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_

Yes No Are you allergic to any medication? \_\_\_\_\_

Yes No Do you have a history of a major illness or operations? \_\_\_\_\_

Yes No Have you ever been involved in a serious accident? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

|                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / Aids               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |

Yes No Do you or have you ever had TB? \_\_\_\_\_

Yes No Do you have a chronic cough? \_\_\_\_\_

Yes No Do you ever cough up blood? \_\_\_\_\_

Yes No Do you have night sweats? \_\_\_\_\_

Are there any other medical conditions you feel we should be aware of? \_\_\_\_\_

What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_

Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_

Yes No Have there been any injuries to face, mouth or teeth? \_\_\_\_\_

Yes No Is any part of your mouth sensitive to temperature or pressure? \_\_\_\_\_

Yes No Do your gums bleed when you brush? \_\_\_\_\_

Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_

Yes No Are you a mouth breather? \_\_\_\_\_

Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_

Yes No Has anyone in your family received orthodontic treatment?  
How did they feel about the result? \_\_\_\_\_

Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_

Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_

Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_

Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_

Yes No Do you have "tension" headaches? \_\_\_\_\_

Yes No Female Patients only: Are you pregnant? \_\_\_\_\_

I consent to the taking of photographs and X-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the Orthodontist to share this patient's treatment information with collaborating dentist and surgeons when appropriate. I authorize the Orthodontist to submit treatment information pertinent to this patient to the insurance company for billing purposes only.

\_\_\_\_\_  
Signature of patient or parent/guardian (if patient under 18)

\_\_\_\_\_  
Date

Our office will not be responsible for any problems arising out of inadequate information not disclosed. Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDA and the ADA.

\_\_\_\_\_  
Signature of Orthodontist

\_\_\_\_\_  
Date