Fey & Grey
ORTHODONTICS

18807 Beardslee Blvd * Suite #101 * Bothell, WA 98011

Welcome to our office. So that we may become better acquainted, please complete <u>both</u> sides of this form.

ADULT PATIENT INFORMATION

Name:_____ Preferred name:_____ Sex:_____

Home address:_____ City:_____ State:_____ Zip:_____

Birthdate:_____ Age: _____ Patient Interests:_____

Home Phone:_____ E-Mail Address:_____

Who noticed orthodontic problem? ☐ Patient ☐ Dentist ☐ Other _____

Describe the orthodontic problem in your own words_____

Do you know a patient currently in our practice? If so, whom_____

Patient's Dentist:_____ Referred by:_____

What concerns you most about the thought of orthodontic treatment?
☐ appearance of appliances ☐ cost ☐ length of treatment time ☐ results ☐ discomfort ☐ other - explain

_____

Occupation:_____

Employer:_____ Address:_____

Work Phone:_____ Work E-Mail address (optional):_____

FAMILY AND ACCOUNT INFORMATION

Spouse's Name:_____ Employer:_____ Work Phone:_____

Person responsible for account:_____

Person responsible for account if other than self or spouse:

Name:_____ Relationship to you? _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Employer:_____ Work Phone:_____

Do you have insurance? Please complete the Insurance Information Sheet to help us assist you in determining benefits.

Your answers to the following questions will be helpful in selecting the safest and most effective means of providing your dental care. All information will be kept completely confidential. Please inform us if any changes should occur.

MEDICAL HISTORY

Physician's Name: _____ Address: _____ Phone: _____

Have you experienced any health problems? ☐ No ☐ Yes Explain: _____
Any major change in your health recently? ☐ No ☐ Yes Explain: _____
Are you currently under a physician's care? ☐ No ☐ Yes Explain: _____
Are you currently taking any medications? ☐ No ☐ Yes List: _____
Are you allergic to any medications? ☐ No ☐ Yes List: _____
Have you received a blood transfusion? ☐ No ☐ Yes Reason: _____
Have your tonsils or adenoids been removed? ☐ No ☐ Yes When: _____
Have you been in a risk group for AIDS? ☐ No ☐ Yes Explain: _____

Please check if you have had any of the following conditions: _____

Heart Murmur	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes	Emotional Problems	☐ No ☐ Yes
Heart Surgery	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Frequent Headaches	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes	Nervous/Anxious	☐ No ☐ Yes
Endocrine Disorders	☐ No ☐ Yes	Liver Disease	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
Prolonged Bleeding	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Bone Disorders	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Growth Disorders	☐ No ☐ Yes
Blood Disease	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes	Sleep Disorder	☐ No ☐ Yes
Developmental Disorder	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	Herpes (fever blisters)	☐ No ☐ Yes
Hives/Rash	☐ No ☐ Yes	Fainting	☐ No ☐ Yes	Tonsilitis	☐ No ☐ Yes

Is there any other condition or problem that you think we should know about? _____

Comments: _____

DENTAL HISTORY

Dentist's Name: _____ Address: _____ Phone: _____

Dental Specialist Name: _____ Address: _____ Phone: _____

Frequency of dental checks: Twice a year ☐ Once a year ☐ Only if a problem exists ☐ Never ☐ Date of last visit: _____

Is there any unfinished care to be completed by your dentist? ☐ No ☐ Yes Explain: _____
Are you frightened about dental treatment? ☐ No ☐ Yes Explain: _____
Have you had an unpleasant experience in a dental office? ☐ No ☐ Yes Explain: _____
Have you had any face or dental injuries? ☐ No ☐ Yes Explain: _____
Do you play a musical instrument? ☐ No ☐ Yes What instrument? _____
Have you consulted an orthodontist previously? ☐ No ☐ Yes With Whom? _____
Have teeth (either primary or permanent) been removed? ☐ No ☐ Yes
Have you had any previous orthodontic treatment? ☐ No ☐ Yes With Whom? _____
Are you satisfied with prior treatment? ☐ No ☐ Yes Explain: _____
Have you noticed any changes in your bite or dental alignment recently? ☐ No ☐ Yes Explain: _____

What are the chief concerns you have related to the position of your teeth or bite:

☐ Aesthetic ☐ Cleaning ☐ Comfort ☐ Ability to chew ☐ Stability

Please elaborate: _____

What concerns has your dentist(s) expressed concerning your bite or dental alignment:

☐ Wear or fractures of teeth
☐ Bone or gum tissue loss
☐ Alignment of teeth prior to restorative dental work (crown, bridge, etc.)
☐ Other _____
☐ Difficulty with cleaning related to alignment of teeth
☐ Jaw joint or muscle tightness or discomfort

Please check if there is any history of:

☐ Clenching teeth ☐ Muscular soreness around head/neck ☐ Jaw joint soreness ☐ Jaw joint popping
☐ Grinding teeth ☐ Headaches (more than normal) ☐ Jaw joint clicking ☐ Ringing in the ears
☐ Speech problems (if so, which sounds _____) ☐ Mouthbreathing: Awake _____ Asleep _____

Is there any other information that might be helpful? _____

I understand that this information is correct to the best of my knowledge. I will keep Fey & Grey Orthodontics informed of any changes in my contact information or health issues that may effect my care.

Patient's Signature: _____ Printed Name: _____
Date: _____ Reviewed By: _____