BOURNE ORTHODONTICS

LAKE STEVENS • MARYSVILLE

bourneorthodontics.com

Confidential Patient Information				
First Name:	Middle Initial:	Last Name:		
Prefers to be called:	Birthdate:	Clinical Gender:	Gender Identity:	
Address:	City:	State:	Zip:	
Best Phone (type):	Secondary Phone (and type):	Best Email:		
If patient is a minor, what is/are the name(s) of the individual(s) who the patient lives with?				
If patient is a minor, please list sibling names and ages.				
What are the names of any friends or family currently in the practice?				
List any sports, hobbies, or interests:				
Whom may we thank for referring you to our practice?				

Responsible Party Information			
First Name:	Middle Initial:	Last Name:	
Marital Status:	Relationship to Patient:	Birthdate:	
Address:	City:	State:	Zip:
How long at this address?			
Best Phone (type):	Secondary Phone (type):	Best Email:	
Employer:	Occupation:	Length of Employment:	
Spouse/Other Parent/Guardian First Name:	Middle Initial:	Last Name:	
Relationship to Patient:	Birthdate:	Employer:	
Occupation:	Length of Employment:	Best Phone (type):	

Dental Insurance Information		
Policy Holder's Name:	Relationship to Patient:	Policy Holder's Employer:
Insurance Company Name:	Subscriber ID:	Group Number:
Insurance Company Phone:		
Does the patient have dual dental coverage? (if yes, complete information below)		
Policy Holder's Name:	Relationship to Patient:	Policy Holder's Employer:
Insurance Company Name:	Subscriber ID:	Group Number:
Insurance Company Phone:		

Orthodontic History	
Dentist Name:	Dentist Office City:
Has the patient previously had an orthodontic consult or treatment? If so, when?	
What is the main orthodontic concern for the patient?	
Please select 'Yes' if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.	
Abnormal swallowing (tongue thrust)?	Apprehensive about dental care?
Seen an Ear, Nose and Throat specialist?	Clench or grind teeth?
Teeth removed by extraction?	Family history of jaw size imbalance?
Injury to face, jaw, teeth, or mouth?	Missing or extra permanent teeth?
Mouth breathing?	Oral habits (thumb/finger sucking, lip/nail biting)?
Pain, tenderness, or noise in either jaw (TMJ)?	Previous periodontal (gum) treatment?
Sleep apnea?	Awaken multiple times overnight?
Well rested in the morning?	Often sleepy during the day?
Sleep walking or night terrors?	Snores during sleep?
Speech problems or therapy?	
Any other dental/orthodontic concerns?	

Medical History		
Physician Name:	Physician City:	
Has the patient had a serious illness or hospitalization in the past 5 years? If so, what for?		
Please list any medications currently being taken by the patient (include non-prescription):		
Allergies or drug reaction to:		
Aspirin, Ibuprofen, or Tylenol?	Latex?	Metal?
Please list any other drug allergies or sensitivities that the patient may have:		
Please select 'Yes' if the patient has had any of the conditions listed below either now or in the past. Cannot be blank.		
Bisphosphonates (Fosamax, Boniva)?	Bone disorders or loss?	Cancer/tumor?
Diabetes or Kidney Disease?	Mental/emotional disorders?	Birth defects/hereditary issues?
Heart disease?	Heart murmur/ congenital heart defect?	Blood disorders?
High blood pressure or hypertension?	Nervous system disorders?	Artificial joints/valves/implants?
Arthritic/rheumatoid disorders?	Seizures, epilepsy, or neurological disease?	Gastrointestinal disorders?
Thyroid or endocrine problems?	Tonsils or adenoids removed?	Tobacco use?
Lung/respiratory disease?	FEMALES: Are You Pregnant?	
Any other medical concerns?		

Patient Motivation for Orthodontic Treatment		
Patients often request changes to their appearance and/or relief from pain or discomfort. Please help us to understand your concerns by selecting the best answers to the following questions. Be as specific as possible. If you are unsure or indifferent to a question, leave it blank.		
If the teeth could be change, how you like them to change for the patient? Please circle.		
Straighten front teeth: Upper, Lower, Both	Move Upper teeth: Forward, Backward, Up, Down	Move lower teeth: Forward, Backward, Up, Down
Eliminate spaces between teeth: Upper, Lower, Both	Move midline of the upper teeth: Left, Right	Move midline of the lower teeth: Left, Right
Other:		

If facial appearance could be changed, what would you like to change for the patient?		
Move upper lip: Forward, Backward	Move lower lip: Forward, Backward	When smiling, show the teeth: More, Less
When smiling, show the gums: More, Less	Move chin: Forward, Backward	Move chin laterally: Left, Right
Other:		

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.