VAKANI orthodontics

Date: _____

Welcome! Our specialty is creating smiles and to do this, we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.

Patient Information

Patients Name _____ Nickname _____
Last First Middle

Address_____
Street City State Zip

Home Phone _____ Cell _____ Birthdate _____ Age _____

If the patient is a minor give parent or guardian's name _____

School _____Email_____

Siblings/Children: Name/Age _____ Name/Age_____

How did you hear about our office? _____

Responsible Party Information

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____Home Phone _____ Work Phone _____

Social Security _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ Years Employed _____

Spouse's Name _____ Birthdate _____

Spouse's Employer _____ Spouse's Social Security _____

Years Employed_____ Occupation _____ Work Phone _____

Orthodontic Insurance Information

Subscriber's Name _____ Subscriber's ID/ SS#_____

Subscriber's Employer: _____ Subscriber's D.O.B. _____

Insurance Company Name _____ Group # _____

Insurance Company Address _____ Phone # _____

Medical History

Physician _____ Date of last visit _____

Address _____ Phone _____

Please check 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? _____
Yes ☐ No ☐ Are you allergic to Nickel or Latex? _____
Yes ☐ No ☐ Have you had any major operations? _____
Yes ☐ No ☐ Have you ever been involved in a serious accident? _____
Yes ☐ No ☐ Are you pregnant? _____

Please check 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

Are there any medical conditions we have not discussed that you feel we should be aware of?

_____

Dental History

Dentist _____ Date of last visit _____

Address _____ Phone _____

What concerns you most about your smile? _____

Yes ☐ No ☐ Do you go for regular check-ups? _____
Yes ☐ No ☐ Are you presently in any dental pain? _____
Yes ☐ No ☐ Have you ever experienced any unfavorable reaction to dentistry? _____
Yes ☐ No ☐ Have you ever lost or chipped any teeth? _____
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? _____
Yes ☐ No ☐ Has anyone in the family received orthodontic treatment? _____
How do they feel about their results? _____
What is your attitude toward receiving orthodontic treatment? _____
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 ☐ Have you ever experienced chronic ringing in your ears? _____
Yes ☐ No ☐ Are you aware that some appointments will be during school/work hours? _____

Benefits of Orthodontics:

AESTHETICS, HEALTH, AND FUNCTION

Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history.

_____ _____

Patient/ Parent Name Date