



# Orthodontic Associates, P.A.

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## PATIENT INFORMATION

Date: \_\_\_\_\_

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_

Birthdate \_\_\_\_\_

Home Phone \_\_\_\_\_

e-mail address \_\_\_\_\_

Sports and Interests: \_\_\_\_\_

What is your reason for seeking orthodontic treatment? \_\_\_\_\_

If patient is an adult: Employer \_\_\_\_\_

Do you have orthodontic insurance? \_\_\_\_\_

If patient is a child list names and birthdates of siblings \_\_\_\_\_

Names of family members we have treated \_\_\_\_\_

## PARENT INFORMATION

(if patient is a minor)

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

Address (if different from above) \_\_\_\_\_

Home Phone \_\_\_\_\_

e-mail address \_\_\_\_\_

Employer \_\_\_\_\_

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

Address (if different from above) \_\_\_\_\_

Home Phone \_\_\_\_\_

e-mail address \_\_\_\_\_

Employer \_\_\_\_\_

Who is responsible for payment? \_\_\_\_\_

## EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Home Phone \_\_\_\_\_

OVER →

**MEDICAL HISTORY**

Has the patient ever been treated for any of the following?

	Yes	No		Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Liver involvement	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney involvement	<input type="checkbox"/>	<input type="checkbox"/>	Nervous disorders	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Latex sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive	<input type="checkbox"/>	<input type="checkbox"/>
Premed for heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Nickel sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Bone disorder	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>			

Is the patient in good health?.....  Yes  No

Does the patient smoke?.....  Yes  No

Does the patient have a history of major illness? \_\_\_\_\_

Can the patient breathe comfortably with the lips closed?.....  Yes  No

Have tonsils and/or adenoids been removed? What age? \_\_\_\_\_  Yes  No

Has the patient begun puberty? If girl, has menstruation begun?.....  Yes  No

If boy, has voiced changed or have facial hair?.....  Yes  No

List any drugs or medications now being taken. Give reasons \_\_\_\_\_

List any allergies or drug sensitivities \_\_\_\_\_

Patient's physician \_\_\_\_\_ Phone # \_\_\_\_\_ Last seen \_\_\_\_\_

**DENTAL HISTORY**

Patient's dentist \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last check up \_\_\_\_\_

Is there any dental work (cavities or fillings) that still needs to be done?.....  Yes  No

Have there been any injuries to the face, mouth or teeth? .....  Yes  No

Has the patient ever sucked a thumb or finger? Until what age? \_\_\_\_\_  Yes  No

Does the patient have any clicking or discomfort in jaw joints near ears?.....  Yes  No

Have you been informed of any missing or extra permanent teeth? .....  Yes  No

Has the patient had a previous orthodontic exam or treatment?.....  Yes  No

If so, who treated? \_\_\_\_\_ When? \_\_\_\_\_

Does the patient clench or grind his or her teeth? .....  Yes  No

Is the patient especially apprehensive toward dental visits? .....  Yes  No

Does the patient have any congenital abnormalities?.....  Yes  No

I understand that, where appropriate, credit bureau reports may be obtained.

SIGNATURE (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_/\_\_\_/\_\_\_ \_\_\_\_\_

Doctor of record \_\_\_\_\_

Date reviewed \_\_\_\_\_