



Smokey Point Orthodontics

Jeff E. Theis, DMD, MSD
Diplomate of the American Board of Orthodontics
3325 Smokey Point Drive, Suite 102 • Arlington, WA 98223 • (360) 659-5749

Confidential Patient Information Form

Patient Information

Today's Date _____

Patient's Name _____

Patient's Address _____

Patient's E-mail Address _____ Birthdate _____ Home Phone _____

Other Family Members Seen By Us _____

General Dentist's Name _____ Who Referred You to Us? _____

Responsible Party Information

Single Divorced Other

Married Widowed

Name _____ Marital Status _____

Responsible Party's Address _____ Years at this Address _____

Previous Address (If Less Than 3 Years) _____

Responsible Party's E-mail Address _____

Social Security Number _____ Birthdate _____ Home Phone _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ Years Employed _____

Spouse's Name _____

Social Security Number _____ Birthdate _____ Home Phone _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ Years Employed _____

Insurance Information

Subscriber's Name _____ Social Security Number _____

Insurance Company Name _____ Group Number _____ Subscriber's Birthdate _____

Insurance Company Address _____ Insurance Company Phone _____

Subscriber's Employer _____

No Yes (Complete this Section)
Do You Have Dual Coverage? _____ Subscriber's Name _____ Social Security Number _____

Insurance Company Name _____ Group Number _____ Subscriber's Birthdate _____

Insurance Company Address _____ Insurance Company Phone _____

Subscriber's Employer _____

Emergency Contact Information

Name of Nearest Relative NOT Living with You _____ Relationship _____

Address _____ Phone _____

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Medical History

Your current physical health is? Good Fair Poor
 Are you currently under the care of a physician? Yes No

If Yes, Please Explain

Are you taking any prescriptions or medications? Yes No

If Yes, Please Explain

Are you currently pregnant? (Week # _____) Yes No

Are you allergic to any of the following?

	Yes	No		Yes	No
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Any Metals/Plastics	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Dental Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>

Please List Any Other Allergies

Have you ever had any of the following diseases or medical problems?

	Yes	No		Yes	No
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery/Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints or Valves	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization/Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fever Blisters/Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Severe/Frequent Headache	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	STDs/Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Colitis	<input type="checkbox"/>	<input type="checkbox"/>

Please list any serious medical condition(s) you have ever had

Dental History

Have you ever had or been evaluated for orthodontic treatment? Yes No

Have you ever had a serious or difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain or discomfort in your jaw (TMJ/TMD)? Yes No

Your current dental health is? Good Fair Poor

Do you like your smile? Yes No

Do your gums bleed? Yes No

Have you ever had an injury to your... Mouth Teeth Chin

Do you have any speech problems? Yes No

If Yes, Please Explain

Do you typically breathe through your mouth? Yes No

Do you grind your teeth? Yes No

Do you have any missing or extra teeth? Yes No

If Yes, Please Explain

What are the main concerns that you would like orthodontics to address?

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date

Thank you for Completing Your Patient Information