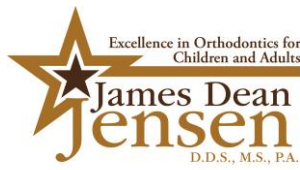


East Plano
1605 G Avenue, Suite 400, Plano, TX 75074
Tel: 972-422-0277 Fax: 972-422-0288
www.jensensmiles.com



West Plano
5800 Coit Road, Suite 500, Plano, TX 75023
Tel: 972-422-0277 Fax: 972-422-0288
www.jensensmiles.com

Chart Number _____ Date _____

PATIENT INFORMATION

Patient's Full Name _____ Nickname _____
(First, Middle, Last)

Patient's Address _____
(Street, Apt. No., City, State, Zip)

Home Phone _____ Cell Phone _____ Email _____

Patient's Date of Birth _____ Age _____ Gender Male Female
(Month, Day, Year)

Marital Status Single Married Divorced Widowed Separated

Patient's Dentist _____
(Name, City, State)

Whom may we thank for referring you? _____

Employer _____ Social Security No. _____

Occupation _____ Work Phone _____ No of Years _____

Names and Ages of Children

(Child Full Name) M/F DOB

(Child Full Name) M/F DOB

(Child Full Name) M/F DOB

RESPONSIBLE PARTY

Who will be responsible for the account? Self Spouse/Partner Other
Please complete the following if the responsible party is anyone other than self:

Full Name _____ Day Time Phone _____
(First, Middle, Last)

Home Address _____ For how long? _____
(Street, Apt. No., City, State, Zip)

Email address _____ Driver's License _____ Birth Date _____
(State, No.)

Employer _____ Social Security No. _____

Occupation _____ Work Phone _____ No of Years _____

Is this the individual providing insurance coverage? Yes No

Please complete insurance information page

Partner/Spouse's Name _____

Partner/Spouse's Occupation _____ Partner/Spouse's Employer _____

EMERGENCY INFORMATION – RELATIVE OR FRIEND NOT LIVING WITH YOU

Medical Emergency Contact's Name _____ Relationship to Patient _____

Contact's Address _____
(Street, Apt. No., City, State, Zip)

Contact's Home No. _____ Contact's Work No. _____

Contact's Cell No. _____

Chart Number _____ Date _____

PATIENT HEALTH QUESTIONNAIRE

Orthodontic Questions	Has an orthodontist been previously consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate the patient's feelings towards orthodontic treatment? <input type="checkbox"/> Eager to get started <input type="checkbox"/> Complacent <input type="checkbox"/> Not committed	In your own words describe the patient's orthodontic problems and what you would like orthodontics to accomplish?
	Has any other family member undergone orthodontic treatment?		
	If yes, who?		
	Does any member of your family or close relatives have similar arrangement of teeth or similar appearance of the jaw?		
Dental Questions	What is your dentist's main concern?	What was the date of your last cleaning? _____	Is there any dental work that needs to be completed prior to orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Physician's Name _____	Is the patient under the care of a physician at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	
Medical Questions	Last physical exam _____		
	Has Patient ever taken Bisphosphonates (Aredia, Zometa, Fosamax, Actonel or Boniva)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List any medications being taken at this time:		
	List any Allergies:		
HEALTH HISTORY		DENTAL HISTORY	

Please check if you have or have had...

- Joint Swelling or Arthritis
- Bone Disorders
- Heart Problems
- Diabetes
- Thyroid Problems
- Kidney Problems
- Rheumatic Fever
- Hepatitis A, B, C, D, or Liver Problems
- Tonsils Removed? If yes, when?
- Adenoids Removed? If yes, when?
- Emotional Problems
- Tuberculosis
- AIDS (Acquired Immune Deficiency Syndrome)
- Anemia
- Asthma
- Epilepsy
- Prolonged Bleeding
- Endocrine Problems
- Osteoporosis

- Injuries to the face, mouth, teeth?
- Thumb, finger, or lip sucking habits
- Speech problems? Details
- Mouth breathing when asleep, awake
- Known missing permanent teeth
- Teeth removed by extraction When? _____
- Tongue thrust problem
- Plays wind or brass instruments
- Clenching or grinding of teeth
- Chronically sore or bleeding gums
- Pain, popping, or locking on opening or closing jaw movement
- Difficulties chewing or swallowing food
- Frequent headaches If yes, headaches per week?
- Muscle tenderness or stiffness in the jaw or neck
- Ringing sounds in the ear, or spells of dizziness
- Previous treatment for TMJ or jaw joint problems. Explain

List any other serious illness, surgeries, medical or dental conditions not mentioned above _____

Consent: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, in order to make a thorough diagnosis of the patient's orthodontic needs, it is my responsibility to inform the office immediately if there are any changes in medical status.

Signature _____

Date _____