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

Excellence in Orthodontics for Children and Adults
James Dean Jensen D.D.S., M.S., P.A.

West Plano
5800 Coit Road, Suite 500, Plano, TX 75023
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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 4/21/17 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 4/19/17
(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. _____

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# PATIENT HEALTH QUESTIONNAIRE

## Orthodontic Questions

Has an orthodontist been previously consulted?

☐ Yes ☐ No

Indicate the patient's feelings towards orthodontic treatment?

☐ Eager to get started
☐ Complacent
☐ 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?

☐ Yes ☐ No

## Medical Questions

Physician's Name

_____

Last physical exam

_____

Is the patient under the care of a physician at this time?

☐ Yes ☐ No

If yes, please explain:

Has Patient ever taken Bisphosphonates (Aredia, Zometa, Fosamax, Actonel or Boniva)? ☐ Yes ☐ No

List any medications being taken at this time:

List any Allergies:

## HEALTH 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

## DENTAL HISTORY

☐ 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