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 (Patients under 18 years of age)

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

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

Home Phone _____ Cell Phone _____

Patient's Date of Birth **4/21/17** Age _____ Gender ☐ Male ☐ Female
(Month, Day, Year)

Patient's School _____ Patient's Hobbies / Sports _____

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

Whom may we thank for referring you? _____

Siblings

_____ _____ _____
(Child Full Name) M/F DOB

_____ _____ _____
(Child Full Name) M/F DOB

_____ _____ _____
(Child Full Name) M/F DOB

Parent's or Legal Guardian's Names _____

Child resides with ☐ Mother ☐ Father ☐ Both Parents ☐ Other

RESPONSIBLE PARTY

Who will be responsible for the account? ☐ Mother ☐ Father ☐ Other

Full Name _____ Daytime Phone _____
(First, Middle, Last)

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

Email address _____ Driver's License No. _____ Birth Date **5/1/17**
(State, No.)

Employer _____ Social Security No. _____

Occupation _____ Work Phone _____ No of Years _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Is this the primary individual bringing the patient to appointments? ☐ Yes ☐ No
If not, who? _____
Relationship _____

Is this the individual providing orthodontic/dental insurance coverage? ☐ Yes ☐ No
Please complete insurance information page

Partner/Spouse Name _____

Partner/Spouse Occupation _____ Partner/Spouse 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 word 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:

List any medications being taken at this time:

List any Allergies:

Has the patient recently experienced a sudden increase in height? ☐ Yes ☐ No

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
☐ If female has menses begun? If yes, when? _____.

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 or staff 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, contact information or insurance.

Signature (Parent or Guardian signature if patient is a minor) Date