

**Walt Babula, D.M.D., M.Sc.O.**  
Specialist in Orthodontics for Children and Adults

GENERAL INFORMATION

EXAM DATE \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_

Patient's mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Occupation or School Level \_\_\_\_\_ Employer/School \_\_\_\_\_

Patient's email address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Wk \_\_\_\_\_

Mom's Name \_\_\_\_\_  Mom  Step-Mom  Guardian

Mom's mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mom's email address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Wk \_\_\_\_\_

Dad's Name \_\_\_\_\_  Dad  Step-Dad  Guardian

Dad's mailing address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Dad's email address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Wk \_\_\_\_\_

Person responsible for account \_\_\_\_\_ Occupation/Employer \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ Wk \_\_\_\_\_

List patient's sports and hobbies \_\_\_\_\_

Does patient anticipate a transfer or move within a year?  Yes  No

If military, list installation and rotation date \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

INSURANCE INFORMATION

Orthodontic insurance?  Yes  No

Name of sponsoring employer \_\_\_\_\_

Orthodontic limit: \_\_\_\_\_

MEDICAL HISTORY: Date of last physical exam \_\_\_\_\_

Is patient in good health?  Yes  No

Is patient presently under the care of a physician?  Yes  No

Has patient had any unusual reaction to medication?  Yes  No

Is patient allergic to latex or metal?  Yes  No

Has puberty begun?  Yes  No

Has patient ever had heart surgery or heart murmur?  Yes  No

Has patient ever had a blood disorder?  Yes  No

Has patient ever had a surgical procedure?  Yes  No

Has patient tested positive for HIV?  Yes  No

Has patient had any of the following? Circle those that apply.

*Osteoporosis, rheumatic fever, hepatitis, AIDS, diabetes, heart disease, asthma, tuberculosis, kidney or liver problems, thyroid condition, stomach ulcers, hormonal imbalance, epilepsy, bleeding problems, nervous disorder, prosthetic implants, high or low blood pressure*

MEDICAL HISTORY UPDATE

DENTAL HISTORY: Date of last dental exam \_\_\_\_\_ Name of family dentist \_\_\_\_\_

Do you have any cavities that need filling?  Yes  No

Has patient had any history of injury to the head, face, or teeth?  Yes  No

How often does patient brush teeth? \_\_\_\_\_

Is patient aware of tooth grinding or clenching habits?  Yes  No

How often does patient floss? \_\_\_\_\_

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

Has patient ever been told he/she has TMD symptoms?  Yes  No

Has patient ever been told he/she has periodontal disease?  Yes  No

Does patient have any of the following jaw joint symptoms? **Circle all that apply**

Pain? Joint noise? Difficulty in opening or closing? Jaw sticking or locking?

Does patient breathe mostly through the mouth, &/or lips usually parted?  Yes  No

Have tonsils &/or adenoids been removed? Date \_\_\_\_\_  Yes  No

*I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that may be needed during diagnosis and treatment.* Please sign and date \_\_\_\_\_ Relationship \_\_\_\_\_

ORTHODONTIC HISTORY:

Describe the orthodontic problem in your own words: \_\_\_\_\_

Has patient had previous orthodontic consultation or treatment?  Yes  No

Is patient aware that the success and length of orthodontic treatment is very dependent upon patient cooperation?  Yes  No

Please give the names of any family members who have been treated at this office. \_\_\_\_\_