# Jeffrey D. Sessions, D.M.D., M.S.D., P.C.
**ORTHODONTICS**

## Patient Information

Patient's Name _____ _____ Date _____
LAST FIRST MIDDLE SEX

Address _____
STREET CITY STATE ZIP

Home Phone _____ Date of Birth _____ Age _____ Parent/Guardian Name _____

School _____ Grade _____ Siblings _____

Whom my we thank for referring you to our office? _____

## Responsible Party Information

Name _____ Marital Status _____
LAST FIRST MIDDLE

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at
this address? _____ Home Phone _____ Work Phone _____

Previous Address
(if less than 3 yrs.) _____
STREET CITY STATE ZIP

Social Security No. _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____

Name 2nd Resp. Party _____
LAST FIRST MIDDLE

Address _____ Home Phone _____ Work Phone _____
STREET CITY STATE ZIP

Social Security No. _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ Yrs. Employed _____

## Orthodontic Insurance Information

Insured's Name _____ Insured's Soc. Sec. No. _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Ins. Co. Phone No. _____

2nd Insured's Name _____ Insured's Soc. Sec. No. _____

2nd Insurance Company _____Group No. _____ Local No. _____

2nd Insurance Co. Address _____ Ins. Co. Phone No. _____

## Emergency Information

Name of nearest relative
not living with you _____ Relationship _____ Phone No. _____

• *PLEASE COMPLETE FORM ON REVERSE SIDE* •

## Dental History

Date History Reviewed _____

Why does patient desire an examination (bite, crookedness, "TMJ", etc.)? _____

Patient's Dentist _____ When was your last dental visit? _____

Has patient had previous orthodontics? _____ If so, state the orthodontist, where, when and treatment received:

_____

**Concerns about X-rays? _____

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Teeth Throb or Ache, Sensitivity to Hot or Cold | ❑ | ❑ | Bone Loss, Periodontal Disease | ❑ | ❑ |
| Irritations to Cheek, Lip, Tongue, Palate | ❑ | ❑ | Any Oral Surgeries | ❑ | ❑ |
| Canker Sores, Cold Sores, Cyst, Abscesses | ❑ | ❑ | Facial Trauma/Injury | ❑ | ❑ |
| Lip, Cheek or Tongue-Biting | ❑ | ❑ | Chipped or Injured Teeth | ❑ | ❑ |
| Food Impaction Between Teeth | ❑ | ❑ | Missing or Extracted Teeth | ❑ | ❑ |
| Bleeding Gums, Gingivitis | ❑ | ❑ | Difficulty in Breathing, Chewing | ❑ | ❑ |
| Gum Recession | ❑ | ❑ | Mouth-breather | ❑ | ❑ |
| Other _____ | | | Thumb or Finger-sucking Habit | ❑ | ❑ |

## Medical History

Patient's Physician and/or Health Care Provider _____

Health Status (good, fair, poor, continuing problems, etc.)? _____

Under a Physician's care? _____ If yes, for what? _____

List of Medications — Prescription & "Over the Counter" _____

List any Allergies: _____

List any Types of Surgery: _____ Blood Transfusions? _____

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Diabetes | ❑ | ❑ | Arthritis | ❑ | ❑ |
| Heart Disease | ❑ | ❑ | Tuberculosis or Lung Problems | ❑ | ❑ |
| Congenital Heart Problems/Defects | ❑ | ❑ | Ear Infections, Ringing in Ears | ❑ | ❑ |
| High/Low Blood Pressure | ❑ | ❑ | Sinus/Airway Problems | ❑ | ❑ |
| Heart Murmur or Valvular Problems | ❑ | ❑ | Hayfever or Asthma | ❑ | ❑ |
| Rheumatic Fever | ❑ | ❑ | Treated with X-Ray Therapy | ❑ | ❑ |
| Prosthetic Hip or Joint | ❑ | ❑ | Herpes, Epstein Barr Virus, etc. | ❑ | ❑ |
| Blood Disease, Hemophilia, Anemia | ❑ | ❑ | AIDS, AIDS Related Complex | ❑ | ❑ |
| Kidney Disorder | ❑ | ❑ | Smoking or Alcohol use | ❑ | ❑ |
| Hepatitis | ❑ | ❑ | Women — Are you Pregnant? | ❑ | ❑ |
| Neurological Disorders | ❑ | ❑ | Other diseases/disorders/etc. _____ | | |

## TMJ - Facial Pain History

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Clench/Grind your Teeth | ❑ | ❑ | Clicking, Popping, etc., Sounds from Jaw Joint | ❑ | ❑ |
| Jaw Open/Close Irregularly | ❑ | ❑ | Ever Received a Severe Blow to the Jaw or Head | ❑ | ❑ |
| TMJ Related Head or Neckaches | ❑ | ❑ | Are you Under a Lot of Stress? | ❑ | ❑ |
| Muscles Tire with Normal Chewing | ❑ | ❑ | Pain/Tenderness in your Cheek/Facial Muscles | ❑ | ❑ |
| Time of day most TMJ problems occur: _____ | | | Episodes of Limited Jaw Opening/Closing/Locking | ❑ | ❑ |

What brings on or starts your TMJ problem: _____

Ever been treated for Jaw Joint Problems, facial muscle spasms or worn a night guard/splint: _____

Describe your problem in words: _____

_____

I have completed the patient information and medical/dental history section to the best of my knowledge and have not withheld any information that may affect either myself or the dental staff during treatment. I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's/Guardian's signature if minor) _____ Date _____