Robert T. Ogden, D.D.S., P.A.

Orthodontics ♦ Dentofacial Orthopedics

"We'd Like to Get To Know You Better !"

Name _____ Sex ____ Age ____ Today's Date _____/_____/_____

Birthdate _____/_____/_____ Marital Status S / M / W / D Nickname _____

Address _____ City _____ Zip _____

SS# _____ Email _____

Home Phone _____ Business Phone _____ Cell Phone _____

Employed by _____ Occupation _____

Person responsible for account _____

Who may we thank for referring you to our office? _____

Hobbies/Interests _____

(Fill out parent & school information below if patient is under age 18)

FATHER _____ MOTHER _____

SS# _____ SS# _____

Address _____ Address _____

City _____ City _____

Employer _____ Employer _____

Work Phone _____ Work Phone _____

Email _____ Email _____

SCHOOL _____ GRADE _____

Brothers/Sisters _____

Adult Patients Only:

SPOUSE _____ SS# _____

Address _____ Phone _____

Employed by _____ Phone _____

Daughters / Sons _____

DENTAL INSURANCE

Insurance Company _____ Name of Insured _____

Insurance Phone _____ SS# of Insured _____

Insurance Address _____

ORTHO COVERAGE $ _____ % _____ **DEDUCTIBLE** _____

PLEASE COMPLETE OTHER SIDE

Has patient had previous orthodontic consultation? _____

Has patient had previous orthodontic treatment? _____

If so, when? _____ Dr's Name _____

DENTAL

How does the patient feel about wearing "braces"? _____

Does anyone else in the family have a similar orthodontic problem? _____

Dentist _____ Last Dental Exam _____

Other Dental Specialists _____

Does the patient currently have or ever experienced any of the following? (Please Circle)

Thumb / Finger Habit	Gum Surgery
Periodontal Disease	Cold Sores / Clenching / Grinding
Tooth Extractions	Nail Biting
Jaw / Joint Pain	Head / Neck Pain or Injury

Is there any other dental information we should know about? _____

_____

MEDICAL

Physician _____ Phone _____

Last Exam _____ Health Status? ❒ Excellent ❒ Good ❒ Poor

Is patient allergic to anything (Drugs, Food, Pollen)? _____

Is patient currently under medical care? If yes, what for? _____

_____

Is patient currently taking any medications? _____

Has patient ever been hospitalized? ❒ Yes ❒ No When / Where? _____

_____

Does the patient currently have or has ever had any of the following? (Please Circle)

Adenoids Removal	Drug Addiction	Major Surgery
AIDS (HIV)	Epilepsy / Seizures	Nasal Airway Problems
Arthritis	Heart Problems	Sinus Problems
Asthma	Hepatitis	Speech Problems
Auto Accident	High Blood Pressure	Tobacco Usage
Bleeding Disorder	Immune Disorders	Tonsils Removed
Cancer	Kidney Problems	Tuberculosis
Cosmetic Surgery	Liver Problems	Tubes in Ears
Diabetes	Lung Problems	Venereal Disease

Is there any other information that we should know about? _____

_____

I hereby authorize Dr. Robert T. Ogden to perform an orthodontic evaluation.

Signature _____ Date _____