

# PRESCOTT ORTHODONTICS

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PRESCOTT, ARIZONA 86305  
(928) 445-7051

## Welcome to our office

Date \_\_\_\_\_

### Administrative and Health History Form

#### Patient Information

Patient's Name	_____	_____	_____	_____	_____	Sex	_____
Address	_____	_____	_____	_____	_____	_____	_____
Home Phone	_____	_____	_____	_____	_____	_____	_____
Family Dentist	_____	_____	_____	_____	_____	_____	_____
Patient's Interests or hobbies _____							
If patient is a minor, give parent's or guardian's name _____							
Names and ages of other children in family _____							
Whom may we thank for referring you to our office? _____							
Email Address _____							

#### Responsible Party Information

Name	_____	_____	_____	_____	_____	_____	_____
Residence	_____	_____	_____	_____	_____	_____	_____
Mailing Address	_____	_____	_____	_____	_____	_____	_____
How long at this address	_____	_____	_____	_____	_____	_____	_____
Previous Address (if less than 3 yrs.)	_____	_____	_____	_____	_____	_____	_____
Social Security#	_____	_____	_____	_____	_____	_____	_____
Employer	_____	_____	_____	_____	_____	_____	_____
Spouse's Name	_____	_____	_____	_____	_____	_____	_____
Employer	_____	_____	_____	_____	_____	_____	_____
Social Security#	_____	_____	_____	_____	_____	_____	_____
Responsible Party Email Address (es) _____							

#### Orthodontic Insurance Information

Insured's Name	_____	_____	_____	_____	_____	_____	_____
Insurance Company	_____	_____	_____	_____	_____	_____	_____
Insurance Co. Address	_____	_____	_____	_____	_____	_____	_____
Do you have dual coverage? Yes No If yes:							
Insured's Name	_____	_____	_____	_____	_____	_____	_____
Insurance Company	_____	_____	_____	_____	_____	_____	_____
Insurance Co. Address	_____	_____	_____	_____	_____	_____	_____

#### Emergency Information

Name of nearest relative not living with you	_____
Complete Address	_____
Phone	_____

I understand that where appropriate, credit bureau reports and employment verification may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

## Medical History

Has Patient had any of the following:

	Yes	No
Aids (or tested HIV positive).....	<input type="checkbox"/>	<input type="checkbox"/>
Cancer.....	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco Use.....	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>
Fainting.....	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever.....	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine or Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergies.....	<input type="checkbox"/>	<input type="checkbox"/>
Removal of Tonsils & Adenoids.....	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur.....	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse.....	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Patient is in good health.....	<input type="checkbox"/>	<input type="checkbox"/>
Patient is under physician's care.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, for what reason _____		
_____		
Are there any impending medical conditions.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, describe _____		
_____		
Patient is taking prescription medications.....	<input type="checkbox"/>	<input type="checkbox"/>
If so, list _____		
_____		
Patient's height_____ weight_____		
<b>For females only;</b>		
Is the patient presently pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient take birth control pills.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>For children and adolescence only:</b>		
Has puberty been reached (start of menstruation or voice change).....	<input type="checkbox"/>	<input type="checkbox"/>
If so, and within the last two years, when? _____		
Does patient require pre-medication or antibiotics		
before dental appointments.....	<input type="checkbox"/>	<input type="checkbox"/>

## Dental History

	Yes	No	
Patient has had a recent dental check-up.....	<input type="checkbox"/>	<input type="checkbox"/>	Date_____
Any missing or extra permanent teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	(For office use only)
Blow or injury to face or teeth.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Night time teeth clenching or grinding habit.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech problem.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clicking or pain when opening jaws.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent mouth breathing - while awake.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent mouth breathing - while asleep.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery to repair cleft lip and/or cleft palate.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
High intake of sweets.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has an orthodontist been consulted previously.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has either parent had orthodontic treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Has patient ever sucked a thumb or fingers? Until what age_____.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
In your own words, what is the dental problem_____			_____
_____			_____
_____			_____

If you have any additional concerns or questions you wish the Doctor to be aware of or you wish the Doctor to answer, please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_