Lang Orthodontics

Galleria Atrium
1407 York Road, Suite 204
Lutherville, MD 21093
410.821.6458

Enchanted Forest Shopping Center
10030 Baltimore National Pike D120
Ellicott City, MD 21042
410.461.2700

Patient's Clinical History/Family Information

Name _____ _____ Age _____ Sex _____ Date of Birth _____/_____/___
Last First M.I.

Address _____
Street City State Zipcode

Phone Numbers for contact_____
Home Cell Work

Patient's Employer_____ Occupation_____

E-mail for contact _____ May we sent a text or e-mail: Yes No

If patient is a minor:

School _____ Grade _____

Father's Name _____ D.O.B. _____
Last First M.I.

Employer _____ Work#_____ Cell#_____

If **father's** information is different from the patient, please indicate:

Address _____ Home#_____
Street City Zip

Mother's Name _____ D.O.B._____
Last First M.I.

Employer _____ Work#_____ Cell#_____

If **mother's** information is different from the patient, please indicate:

Address _____ Home#_____
Street City Zip

Employer _____ Work#_____ Cell#_____

Who is accompanying this child today? Name_____ Relation_____
Do you have legal custody? Yes or No

Primary Orthodontic Insurance Information

Does the patient have orthodontic coverage? _____ Yes _____ No

Insurance Company _____
Name Phone Number

_____
Address City State Zip Code

Policy Owner _____DOB _____ Relationship_____
Last First

Employer _____ Group # _____ Policy # _____

Patient's Family Dentist _____ Family Physician _____

Medical History

Has patient had or does patient have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐
High Blood Pressure	☐	☐	Heart Attack/Stroke	☐	☐
Blood Vessel Disease	☐	☐	Blood Disorder	☐	☐
AIDS/HIV Infection	☐	☐	Hepatitis	☐	☐
Diabetes	☐	☐	Ulcers	☐	☐
Herpes (any type)	☐	☐	Psoriasis	☐	☐
Cancer	☐	☐	Persistent Headaches	☐	☐
Neck Pains	☐	☐	Nerve or Brain Disease	☐	☐
Migraine	☐	☐	Epilepsy	☐	☐
Mental Health Problems	☐	☐	Bone Disorders	☐	☐
Arthritis (any type)	☐	☐	Sleep Apnea	☐	☐
Ear Disorder	☐	☐	Sinus Infection	☐	☐
Swollen Glands	☐	☐	Allergies	☐	☐

Yes No

☐ ☐ Is patient under a physicians care at present? If yes, why _____

☐ ☐ Is patient currently taking any medication? If yes, describe _____

☐ ☐ Is the patient allergic to any medication? If yes, describe _____

☐ ☐ Has the patient ever had general anesthesia? When and why _____

☐ ☐ Is the patient pregnant?

Comments _____

Please list any other significant information about the patient's medical history _____

_____

Dental History

Yes No

☐ ☐ Do any of your teeth hurt? If yes, upper right ☐ upper left ☐ lower right ☐ lower left ☐

☐ ☐ Have any of your wisdom teeth been removed? How many? _____

☐ ☐ Have you ever had any treatment for a periodontal disease (gum disease)? If yes, describe _____

☐ ☐ Have you ever had any previous orthodontic treatment? If yes, when and where _____

☐ ☐ Have there been any injuries to your mouth or teeth? If yes, describe _____

☐ ☐ Have you ever had any injury in the head or neck area? If yes, describe _____

☐ ☐ Have you ever had surgery in the head or neck area? If yes, describe _____

☐ ☐ Do you clench or grind your teeth? If yes, while sleeping ☐ under stress ☐ other _____

☐ ☐ Do your jaw muscles ever feel tired? If yes, when _____

☐ ☐ Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe _____

_____

☐ ☐ Does it hurt to chew? If yes, when does it hurt _____

☐ ☐ Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when	During what activity
☐ Clicking	☐	☐		
☐ Grating	☐	☐		

Did these joint sounds begin gradually or suddenly? ☐ gradually ☐ suddenly

☐ ☐ Was there some specific event that started the joint sounds? If yes, describe _____

☐ ☐ Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

☐ ☐ Have your jaws ever "locked" closed? If yes, describe _____

☐ ☐ Have your jaws ever "locked" wide open? If yes, describe _____

☐ ☐ Do you have any pain in your jaw joints? If yes, describe _____

Do you have any of the following habits?

☐ ☐ Finger/Thumbsucking

☐ ☐ Lip biting

☐ ☐ Nail biting

☐ ☐ Gum chewing

☐ ☐ Ice chewing

Other Information

Yes No

☐ ☐ Are there any other children in the familyt?
Names and ages _____

☐ ☐ Has any other member of the family had orthodontic treatment?

☐ ☐ Has any other member of the family been a patient in this office?
Name _____

Please describe why you sought this consultation? _____

☐ ☐ Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment ____
_____

Patient's attitude toward dentistry? _____

Whom may we thank for referring you? _____

Any other information that you can give me concerning the patient will be appreciated. The more we know about each patient, the more we can help in managing the orthodontic treatment, both at home and in the office. _____
_____
_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it to be accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____
(Signature of Responsible Adult) (Date)

I understand and agree that I am completely responsible for payment, despite the fact that I may have insurance coverage. If it becomes necessary to send my account to collections, I understand and agree that treatment will be suspended until my account is current and that I will pay all reasonable fees related to collections, including but not limited to lawyer's fees, court costs and the cost of a private process server to the owed amount. Any unpaid balance would be subject to interest at the annual rate of 15%.

_____ _____
(Signature of Responsible Party or Authorized Person) (Date)