



Welcome to Seim Orthodontics! Please take a minute to fill out our adult health history form and email to info@seimortho.com or print and bring with you to your first appointment.

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____

Patient's name _____
Last First Middle

Nickname _____ Gender _____ Social Security # _____ Birthdate _____

Mailing Address _____
Street City Zip

Cell Phone _____ Carrier _____ Email Address _____

If patient will schedule his/her own appointments, select reminder preference(s): Text Message__ Email__ Mail__

School _____ Sports/Hobbies _____

Parent/Guardian's Name _____ Relationship to patient _____

Mailing Address _____
Street City Zip

Cell Phone _____ Carrier _____ Email Address _____

If this person will schedule patient's appointments, select reminder preference(s): Text Message__ Email__ Mail__

Employer _____ Occupation _____ Work Phone _____

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

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Social Security # _____ Birthdate _____ Relationship to Patient _____

Mailing Address _____
Street City Zip

Cell phone _____ Carrier _____ Email address _____

If this person will schedule patient's appointments, select reminder preference(s): Text Message__ Email__ Mail__

Employer _____ Occupation _____ Work Phone _____



DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Emergency contact name _____ Relationship to patient _____ Phone _____

Complete address _____
Street City Zip

MEDICAL HISTORY

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

- Yes No Are you taking any medication? _____
- Yes No Do you have any allergies, including latex or nickel? _____
- Yes No Do you have a history of a major illness? _____
- Yes No Have you had any operations? _____
- Yes No Have you ever been involved in a serious accident? _____
- Yes No Have you ever smoked or chewed tobacco? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Female Patients only:
- Yes No Are you pregnant? _____
- Yes No Has menstruation started? _____

Circle any of the medical conditions below that you have had or currently have.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____



DENTAL HISTORY

General Dentist _____ Date of last visit _____

What concerns you most about your teeth? _____

- Yes No Are you presently in any dental pain? _____
- Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have your wisdom teeth been removed? _____
- Yes No Have you ever lost or chipped any teeth? _____
- Yes No Have there been any injuries to face, mouth, or teeth? _____
- Yes No Is any part of your mouth sensitive to temperature? Where? _____
- Yes No Is any part of your mouth sensitive to pressure? Where? _____
- Yes No Do your gums bleed when you brush? _____
- Yes No Do you have any type of thumb or tongue habit? _____
- Yes No Are you a mouth breather? _____
- Yes No Have you ever seen an orthodontist? If yes, who and when? _____
- Yes No What is your attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in your family received orthodontic treatment? _____
- Yes No How did they feel about the result? _____
- Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
- Yes No Are you aware of your jaw clicking or popping? _____
- Yes No Are you aware of clenching your teeth during the day? _____
- Yes No Have you ever been told that you grind your teeth? _____
- Yes No Do you have "tension" headaches? _____
- Yes No Have you ever experienced chronic ringing in your ears? _____
- Yes No Are you aware that some appointments will be during school/work hours? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Lisa Seim to perform a complete orthodontic evaluation.

Signature: _____ Date: _____

