John Mark Griffies, DDS, PLLC **Date: _________**
dba Straighten-Up Orthodontics

Patient's Clinical History/Family Information

Name_____________________________________ Age________ Sex________ Date of Birth___________
Last First M.I. Mo / Day / Yr

Address____Tel.#( )___________
Street City Zip

School____ Grade__________ S.S.# of Patient___________

Best telephone number to call for appointments (During Business Hours)___________________________

Best Fax #______________ Best Cell Phone #_______________ Best E-mail address_________________

Father's Name____ Father's SS #______________________
Last First M.I. **(for accounting purposes only)**
Date of Birth ___________________
Marital Status:
□ Single □ Married □ Separated □ Divorced □ Widowed □ Remarried
Home Address____Tel # ( )___________
Employed by______________________________ Occupation_______________ Position ______________
Office Address ____ Work Tel # ___________
Does Father have Orthodontic Insurance? ___ Yes ___ No Name of Insurance Co. __________________
Does Father have Medical Insurance? ___ Yes ___ No Name of Insurance Co. __________________

Mother's Name_______________________________________ Mother's SS #______________________
Last First M.I. **(for accounting purposes only)**
Date of Birth __________________
Marital Status:
□ Single □ Married □ Separated □ Divorced □ Widowed □ Remarried
Home Address____Tel # ( )___________
Employed by______________________________ Occupation_______________ Position ______________
Office Address ____Work Tel # ____________
Does Mother have Orthodontic Insurance? ___ Yes ___ No Name of Insurance Co. _________________
Does Mother have Medical Insurance? ___ Yes ___ No Name of Insurance Co. _________________

Patient's Family Dentist____

Patient's Family Physician____

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

If responsible party is other than the patient's parents, please give information: □ Not Applicable

Name_______________________________ S.S. # ____________ Relationship to Patient______________

Address____Tel # ( )__________

Does responsible party have Orthodontic Insurance? ___ Yes ___ No Name of Insurance Co__________
Does responsible party have Medical Insurance? ___ Yes ___ No Name of Insurance Co__________

Patient Name: ________________

MEDICAL HISTORY:

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

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

Comments____

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

____

____

Yes	No	
□	□	Is patient under a physician's care at present? If yes, reason__________________________
□	□	Is patient presently, or has patient ever been, under the care of a psychiatrist or psychologist? If yes, describe__________________________
□	□	Is patient currently taking any medication? If yes, describe__________________________
□	□	Is the patient allergic to any medications? (Eg. Aspirin, penicillin, etc.) If yes, what?__________
□	□	Has patient ever had any general anesthesia? When and why?__________________________

DENTAL HISTORY:

Yes	No	
□	□	Do any of your teeth hurt? If yes, upper right □ upper left □ lower right □ lower left □
□	□	Have any wisdom teeth been removed? How many?__________________________
□	□	Have any other teeth been removed? If yes, describe__________________________
□	□	Have you ever had treatment for periodontal disease (gum disease)? If yes, describe__________
□	□	Have you ever had any previous orthodontic treatment (braces)? If yes, when______________ If yes, doctor's name and address__________________________ If yes, were they removed prior to completion? Yes □ No □ If yes, describe why they were removed early__________________________
□	□	Have there been any injuries to your mouth or teeth? If yes, describe______________________
□	□	Have you ever had any injury in the head and neck area? If yes, describe___________________
□	□	Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe.
□	□	Have you ever had any surgery in the head and neck area? If yes, describe_________________
□	□	Do you clench or grind your teeth? If yes, while sleeping □ under stress □ other____________

Patient Name: ________________

Yes No

□ □ Do your jaw muscles ever feel tired? If yes, explain____________________________________

____

□ □ 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, where 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 pain in you jaw joints? If yes, right □ left □ Since when?_________________

□ □ Did your pain start gradually or suddenly? Gradually □ Suddenly □

During what activity?_________________ Describe nature of pain______________________

What increases the pain?______________ What decreases the pain?_____________________

Do you have any of the following habits?

Yes No

□ □ Finger/Thumbsucking

□ □ Lip Biting

□ □ Nail Biting

□ □ Gum Chewing

□ □ Ice Chewing

GROWTH AND DEVELOPMENT

Yes No

□ □ Has patient reached adolescent growth?____

□ □ Girls – Has monthly cycle started yet? If so, when____________________________________

□ □ Boys – Has voice changed yet? If so, when____

□ □ Is the patient adopted? Does the patient know? Yes □ No □

□ □ Are there any learning disabilities? If yes, explain_____________________________________

Patient's present height___________ Expected height of patient____________

Father's height_____________ Mother's height______________

Patient's weight____________

□ □ Are there other children in the family?

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(s)____

Patient Name: ________________

Please describe why you sought this consultation____
____
____
____

Yes No
☐ ☐ Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment____
____

Any information you can give me concerning you or your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies: ____________________________________
____
____
____
____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it 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

Doctor's Notes ____
____
____
____
____

____________________________________ ____________________________________
(Doctor's Signature) Date

SIGNATURE PAGE

PATIENT NAME: ________________________________ DATE: _______________

PARENT OR GUARDIAN NAME: ____________________________________

I HAVE READ AND UNDERSTAND THE POLICY TOWARD VISITING YOUR DENTIST AND USING A PRESCRIPTION FLUORIDE EVERY NIGHT.

*PATIENT SIGNATURE:*___________________________________

PARENT OR GUARDIAN SIGNATURE: ____________________________________

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES OF DR. GRIFFIES AND STRAIGHTEN-UP ORTHODONTICS.

*PATIENT SIGNATURE:*___________________________________

PARENT OR GUARDIAN SIGNATURE: ____________________________________

I HAVE READ AND UNDERSTAND THE PRIVACY NOTICE AND PRIVACY AUTHORIZATION FOR DR. GRIFFIES AND STRAIGHTEN-UP ORTHODONTICS.

*PATIENT SIGNATURE:*___________________________________

PARENT OR GUARDIAN SIGNATURE: ____________________________________

I HAVE READ AND UNDERSTAND THE LETTER OF INFORMATION AND CONSENT AGREEMENT FOR ORTHODONTICS AND ALL OF MY QUESTIONS PERTAINING TO THE ORTHODONTIC TREATMENT PROPOSED HAVE BEEN ANSWERED.

*PATIENT SIGNATURE:*___________________________________

PARENT OR GUARDIAN SIGNATURE: ____________________________________