CONFIDENTIAL PATIENT INFORMATION

FOOTHILL
1400 S. Foothill Dr., # 240
Salt Lake City, UT 84108

HOLLADAY
1548 E. 4500 S., #103
Salt Lake City, UT 84117

foothillortho.com
801-581-1234

Jeffrey R. Chandler DDS, MS
Brian C. Anderson DDS, MS

FOOTHILL
ORTHODONTIC SPECIALISTS

Date _____

Name: Last _____ First _____ Middle _____

Common Name _____ Gender: ☐ M ☐ F Age _____ Birth Date _____

Address _____ City _____ State _____ Zip _____

Phone _____ Parent/Guardian Name _____ Cell Carrier _____

Email Address _____

RESPONSIBLE PARTY'S INFORMATION

Name: Last _____ First _____ Init. _____ Marital Status _____

Birth Date _____ Relation to patient _____

Mailing Address _____ City _____

State _____ Zip _____ How long at this address _____ ☐ Own ☐ Rent

Previous Addr. *(if less than 3 yrs)*: _____ City _____ State _____ Zip _____

Employer _____ Occupation _____ Work Phone _____ Yrs. Empl. _____

SPOUSE

Name: Last _____ First _____ Init. _____ Birth Date _____

Relation to Patient _____

Employer _____ Occupation _____ Work Phone _____ Yrs. Empl. _____

INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec # _____

Employer _____ Employer Address _____

Insurance Co. _____ Group No. _____ Subscriber ID # _____

Insurance Co. Address _____ Phone _____

Do you have Dual Coverage? ☐ Yes ☐ No If yes, complete the following:

2nd Insured's Name _____ 2nd Insured's Soc. Sec. # _____

Employer _____ Employer Address _____

Insurance Co. _____ Group No. _____ Subscriber ID # _____

Insurance Co. Address _____ Phone _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Address _____ Phone _____

I certify that the above information is accurate and I agree to inform this office of any changes to the above information in the future. I understand that, where appropriate, credit bureau reports may be obtained.

Signature *(Parent's Signature if minor)* _____

Updates *(Date & Initial)* _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

MEDICAL HISTORY

Physician _____ Dentist _____

Does the patient:

Yes	No	
☐	☐	Have any health problems *(current or past)* _____
☐	☐	Take any medications *(current or past)* _____
☐	☐	Currently see a physician _____
☐	☐	Have allergies to anything _____
☐	☐	Have a history of illness or hospitalizations _____
☐	☐	Use drugs, alcohol or tobacco _____
☐	☐	Have trouble breathing through the nose _____
☐	☐	Have a tendency for ear infections _____
☐	☐	Have a history of bumps to the chin or trauma to the face, teeth or jaws _____
☐	☐	Have any pain, clicking or noises in the jaw joint or head/neck regions _____
☐	☐	Experience frequent headaches _____
☐	☐	Play any wind/reed instruments or the violin _____
☐	☐	Have negative reactions or experiences to any type of dental work _____
☐	☐	Need to take medication before dental work because of a heart/valve condition _____
☐	☐	Have airway concerns or been diagnosed with Sleep Apnea _____
☐	☐	Have a history of thumb sucking, if yes, until what age? _____

Has the patient ever had any of the following *(Check all that apply)***:**

- ☐ Heart Trouble, Congenital Heart Lesions
- ☐ Heart Murmur
- ☐ High or Low Blood Pressure
- ☐ Rheumatic Fever, Heart Valve Problems
- ☐ Arteriosclerosis or Stroke
- ☐ Chest Pains or mild exertion
- ☐ Shortness of Breath on mild exertion
- ☐ Kidney Disease or problems
- ☐ Excessively Swollen Ankles or Tissues
- ☐ Anorexia, Bulimia
- ☐ Venereal Disease
- ☐ Scarlet Fever
- ☐ Liver Disease
- ☐ Hepatitis, Jaundice, Liver Problems
- ☐ Hearing Problems, Ringing in the Ears
- ☐ Cold Sores, Herpetic Lesions, Cankers
- ☐ Skin Rash, Lesions, Hives, Fever Blisters
- ☐ Prostate Disorders
- ☐ Glaucoma, Cataracts
- ☐ Sudden Weight Change
- ☐ Blood Transfusion
  If so, when _____
- ☐ Diabetes or a Family History of same
- ☐ Excessive Chronic Thirst
- ☐ Thyroid Disorders or Family History
- ☐ Endocrine Disturbances
- ☐ Anemia, Blood Diseases
- ☐ Bleeding Disorders, Prolonged Bleeding
- ☐ Arthritis, Sore or Swollen Joints
- ☐ Tuberculosis, Chronic or Frequent Cough
- ☐ Mononucleosis or Other Viral Disease
- ☐ HIV Virus or AIDS
- ☐ Ulcers, Internal Bleeding
- ☐ Emphysema, Breathing Problems
- ☐ Asthma, Respiratory Problems
- ☐ Radiation Treatment, Chemotherapy
- ☐ Malignancies, Tumors, or Growths
- ☐ Epilepsy or Seizures
- ☐ Hyperactivity, Nervousness
- ☐ Fainting, Dizziness, Unconsciousness
- ☐ Chronic Exhaustion or Fatigue
- ☐ Chronic Nervousness, High Stress
- ☐ Chronic Unhappiness or Depression
- ☐ Emotional Problems or Tension
- ☐ Psychiatric Treatment

For the Female Patient...is the patient now:

Yes	No		Yes	No	
☐	☐	Pregnant?	☐	☐	Have you ever taken Bisphosphonates for bone density? When? _____
☐	☐	Taking Birth Control?	☐	☐	Are you currently taking Bisphosphonates?

Please explain fully any "Yes" answers above or any family history of any of the above conditions.

_____

_____

Please explain your orthodontic concerns and what you would like orthodontics to accomplish for you.

_____

_____

I certify that the information above is true and accurate and that if there are any changes in this medical history, I will notify this office. I agree to allow Dr. Chandler and/or Dr. Anderson to discuss or share this information with whomever they deem necessary.

Patient/Legal Guardian Signature _____ Date _____