

# Journey Orthodontics, Prof. L.L.C.

Brian J Hohlen, DDS, MS Michael P Tewes, DDS, MS

3500 S. Marion Rd  
Sioux Falls, SD 57106  
605-361-0016  
Fax: 605-361-0019

4804 S. Cliff Ave  
Sioux Falls, SD 57103  
605-271-8828

520 N. Sycamore Ave  
Sioux Falls, SD 57110  
605-271-9294

812 Belfast  
Yankton, SD 57078  
605-665-0061  
Toll Free: 888-241-0016

Please completely fill out all of the information on this form. Please sign the form where indicated and bring it with you to your first appointment. Thank you!

## **Patient Information**

Date \_\_\_\_\_ Nick Name \_\_\_\_\_

Patient's Name \_\_\_\_\_ Patient lives with:  Mother  Father  
First Middle Last  Both  Guardian

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

If patient is a minor, give parent or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_ Dentist \_\_\_\_\_

Name of relatives treated here \_\_\_\_\_ Relation \_\_\_\_\_

## **Responsible Party Information**

**Primary**  Mother  Father  Step Parent  Self  Other (specify) \_\_\_\_\_

Responsible Party \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ How Long \_\_\_\_\_

Employer/Address \_\_\_\_\_ Telephone \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthday \_\_\_\_\_



For the following questions circle yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

### Medical History

- yes no dk/u Birth defects or heredity problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes?
- yes no dk/u Cancer or been treated for a tumor?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis, pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u Hepatitis, jaundice or liver problems?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Sexually transmitted diseases?
- yes no dk/u Fainting spells, seizures, epilepsy or neurologic disease?
- yes no dk/u Mental health or behavioral problems?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u Excessive bleeding, black and blue tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Easily tired?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?
- yes no dk/u Cardiovascular problems (heart trouble, heart attack, angina, coronary, insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart)?
- yes no dk/u Skin disorder?
- yes no dk/u Do you have a normal and good diet?
- yes no dk/u Frequent headaches, cold or sore throats?
- yes no dk/u Any history of speech problems?
- yes no dk/u Eye, ear, nose, throat condition?
- yes no dk/u Hay fever, asthma, sinus trouble, hives?
- yes no dk/u Tonsils/Adenoids removed? Age: \_\_\_\_\_
- yes no dk/u Allergies or drug reactions?
- yes no dk/u Are you taking medication, nutrient supplements or nonprescription medicine? Please name them.  
\_\_\_\_\_
- yes no dk/u Do you currently have or ever had a substance abuse problem?
- yes no dk/u Operations? \_\_\_\_\_ When? \_\_\_\_\_
- yes no dk/u Hospitalization? For \_\_\_\_\_
- yes no dk/u Other physical problems or symptoms?
- yes no dk/u Being treated by another health care professional? For \_\_\_\_\_ Name \_\_\_\_\_
- yes no dk/u Are you in good health? Date of most recent physical exam \_\_\_\_\_  
Name of Primary Physician \_\_\_\_\_

## Dental History

- yes no dk/u Chipped or otherwise injured permanent teeth?
- yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u Jaw fractures, cysts, mouth infections?
- yes no dk/u "Dead Teeth" root canals treated?
- yes no dk/u Bleeding gums, bad taste, mouth odor?
- yes no dk/u Periodontal "Gum Problems"
- yes no dk/u "Gum Boils" frequent canker sores, cold sores?
- yes no dk/u Thumb, finger, sucking habit? Until\_\_\_\_\_
- yes no dk/u Abnormal swallowing habit (tongue thrust)?
- yes no dk/u Mouth breathing habit, snoring, difficulty breathing?
- yes no dk/u Tooth grinding, jaw clenching, clicking, locking?
- yes no dk/u Experience any pain or soreness in the muscles of your face or around your ears?
- yes no dk/u Any pain in jaw or ringing in ears?
- yes no dk/u Been treated for TMJ problems (jaw joint or facial pain) ?
- yes no dk/u Difficulty encountered in chewing or jaw opening?
- yes no dk/u History of supernumerary (extra) or congenitally missing teeth?
- yes no dk/u Have any permanent teeth been removed?
- yes no dk/u Aware of loose, broken or missing restorations?
- yes no dk/u Any teeth irritating, cheek, lip, tongue, palate?
- yes no dk/u Ever had orthodontic treatment or worn a bite plate or retainer?
- yes no dk/u Are you seeking a second opinion from us?
- yes no dk/u Ever had Periodontal (gum) treatment?
- yes no dk/u Concerned about space, crooked, protruding teeth?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u Any wisdom tooth problems?
- yes no dk/u Have you had any serious trouble associated with any previous dental treatment?

## Female Patient

- yes no dk/u Are you pregnant?
- yes no dk/u Are you taking birth control pills?
- yes no dk/u Are you anticipating becoming pregnant?
- yes no dk/u Have you started menstruating?

I have read and understand the above questions, I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form AND If there are any changes later to the personal information or the medical/dental status, I will inform this practice AND I understand that I am responsible for payment for any service/treatment provided. I further understand that my credit reports may be obtained prior to Crist & Wenande Orthodontics, Prof. L.L.C. extending me credit for any service/treatment.

Signature (parent if a minor) \_\_\_\_\_ Date \_\_\_\_\_