Kelly E. Morgan DMD, MS
Specialist in Orthodontics
and Dentofacial Orthopedics
www.morganorthodontics.com

19420 Golf Vista Plaza, Suite 120
Lansdowne, VA 20176
T: 703.723.5900 F: 703.723.5592
E:dr@morganorthodontics.com

Date_____

PATIENT INFORMATION

Patient's Full Name_____ Date of Birth _____Age _____Sex_____
Address_____City/State_____Zip Code_____
Home Phone_____School_____
Email_____
Names of Brothers and Sisters _____
Hobbies and Interests_____ Sporting Activities_____
Names of friends or relatives who were former patients_____
If patient is a minor, give parent's name or guardian's name_____
Whom may we thank for referring you to our office? _____

Patient's Dentist_____ **Patient's Physician**_____

RESPONSIBLE PARTY INFORMATION (for patients under the age of 18)

Father_____
Mailing Address_____
Home Phone_____ Cell Phone_____ Work Phone_____ Date of Birth_____
Employer_____Occupation_____ Social Security #_____

Please Circle Parents are: Married Separated Divorced Widowed Never Married

Mother_____
Mailing Address_____
Home Phone_____ Cell Phone_____ Work Phone_____ Date of Birth_____
Employer_____Occupation_____ Social Security #_____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #_____
Insurance Company_____ Group #_____Local #_____
Insurance Company Address_____
Insurance Company Phone #_____Insured's Employer_____

Do you have dual coverage? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #_____
Insurance Company_____ Group #_____Local #_____
Insurance Company Address_____
Insurance Company Phone #_____Insured's Employer_____

EMERGENCY INFORMATION

Name of emergency contact person_____
Relation_____ Phone #_____

DENTAL HISTORY

Does patient receive regular dental checkups? YES NO
Last dental exam_____ Last dental x-rays_____

Has patient received any previous orthodontic consultation or treatment? _____

How often does patient brush their teeth? _____ Is floss used?_____ How often?_____

Does the patient currently have, or has the patient ever had any of the following?

Y	N	Periodontal disease
Y	N	Gum surgery
Y	N	Root canals, crowns or bridges
Y	N	Any clicking, popping or pain of jaw, joints (TMJ)
Y	N	Any missing or extra teeth
Y	N	Trouble chewing
Y	N	Any past facial or mouth injuries? What? _____

What are you or your Dentist most concerned about? (Purpose of visit)_____
_____

ORAL HISTORY

The following are some habits commonly found which may influence tooth position. List info as pertains to patient:

Y	N	Thumb sucking / until age_____	Y	N	Finger sucking / until age____
Y	N	Nail biting	Y	N	Mouth breather
Y	N	Grinding of Teeth			

Other habits_____

Has patient ever had any speech therapy? _____

List any musical wind instruments played_____

HEALTH HISTORY

Has patient been under the care of a physician during the past two years? (other than routine checks) Y N
If yes, what for? _____
Is patient currently taking medications? _____
Is patient allergic to anything (drugs, food, pollen, etc.)?_____

Does the patient currently have, or has the patient ever had any of the following?

Y	N	Tonsils Removed	Y	N	Epilepsy / Seizures	Y	N	Nasal airway problems
Y	N	Adenoids removed	Y	N	Asthma	Y	N	Sinus problems
Y	N	Heart Problems	Y	N	Bleeding problems	Y	N	Speech problems
Y	N	Diabetes	Y	N	High Blood Pressure	Y	N	Arthritis
Y	N	Anemia	Y	N	Immune Disorders	Y	N	Tobacco usage
Y	N	Pneumonia	Y	N	Lung Problems	Y	N	Respiratory problems
Y	N	Hepatitis	Y	N	Tuberculosis			

Does the patient have any special problems not listed above? _____
_____

Our Policy is to have an appointment reminder for every patient for every appointment. Please let us know which method of contact you prefer to receive your reminder and fill in the appropriate information.

☐ **Phone Call/ Voicemail** _____-_____-_____

☐ **Text** _____-_____-_____

☐ **Email** _____@_____