Kelly E. Morgan DMD, MS
Board Certified Orthodontist
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_________________________________ SSN_________ ____________
Email_____________________________________

Names of friends or relatives who were former patients____
Who may we thank for referring you to our office? ____

Patient's Dentist__________________________________ **Patient's Physician**_______________________________________

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, 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___________________________________

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)____
____

CONTINUED ON BACK --------->

caringly creating beautiful smiles

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

Have you been diagnosed or treated for osteoporosis? Y N

If yes, have you ever taken or are you now currently taking:
Fosamax Didronel Boniva Actonel Reclast or a generic form of Bisphosphonates

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

EMERGENCY INFORMATION

Name of emergency contact person____
Relation____ Phone #_____________________