

# Welcome to Our Office

Dr. Michael Uhde  
Specialist in Orthodontics  
Preferred Invisalign Provider



## Patient Information

**Full Name** \_\_\_\_\_

**Nickname ( if preferred)** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Male / Female**

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

**Name of School** \_\_\_\_\_

**Hobbies or Sports activities** \_\_\_\_\_

**Mother's name** \_\_\_\_\_ **S.S.#** \_\_\_\_/\_\_\_\_/\_\_\_\_

**address (if different)** \_\_\_\_\_

**phone (home)** \_\_\_\_\_ **cell#** \_\_\_\_\_

**contact e-mail address** \_\_\_\_\_

**employer** \_\_\_\_\_ **work#** \_\_\_\_\_

**Father's name** \_\_\_\_\_ **S.S.#** \_\_\_\_/\_\_\_\_/\_\_\_\_

**address (if different)** \_\_\_\_\_

**phone (home)** \_\_\_\_\_ **cell#** \_\_\_\_\_

**employer** \_\_\_\_\_ **work#** \_\_\_\_\_

**Parents are:** married divorced separated widowed (please circle)

**Do you have any immediate family members presently in treatment here or who have had previous treatment in this office?** Yes / No **Names** \_\_\_\_\_

**Do you have dental insurance?** Yes / No

## Medical Information

**Name of Physician** \_\_\_\_\_

**Are you allergic to anything (including penicillin)?** \_\_\_\_\_

**Do you have any of the following medical problems? (if yes, please circle)** ASTHMA BLEEDING  
CLEFT PALATE HAY FEVER HEART MURMUR HEPATITIS DIABETES ALLERGIES  
RHEUMATIC FEVER HIV Positive TREATMENT FOR OSTEOPOROSIS

**Are you taking any medication of any type at this time? (please list)** \_\_\_\_\_

\_\_\_\_\_

**Is there any medical information that should be brought to our attention?** \_\_\_\_\_

\_\_\_\_\_

## Dental History

Name of Dentist \_\_\_\_\_

Who referred you to this office? (dentist, hygienist, friend, phonebook, family member, website)

What concerns you most about your teeth?

Have you ever injured your teeth or jaws? ( falls, bumps, etc.)

Have you ever seen an orthodontist? If yes, who and when (approx.) \_\_\_\_\_

Do you have any problems breathing through your nose? \_\_\_\_\_ If yes, is this allergy related? \_\_\_\_\_

Do you snore? Yes / No

Do you grind or clench your teeth? Yes / No

If Yes, when? \_\_\_\_\_

When you open and close your mouth is there any clicking or pain? Pain / Clicking / Both

Is there any other dental information that should be brought to our attention? \_\_\_\_\_

## Authorization

Orthodontic treatment is a service that provides an improvement in the appearance of the teeth and in general dental health and function. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment.

I have read and understand the above. I also understand that my diagnostic records and my name (or my child's) may be used for educational and promotional purposes.

The information that I have given is correct to the best of my knowledge, and I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in medical or dental status.

Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / 20 \_\_\_\_\_