Sletten & Brettin Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
1820 Market Dr, Unit B, Stillwater, MN 55082 Phone: 651-439-3350
944 Carmichael Rd., Hudson, WI 54016 Phone: 715-377-2155

Patient Information

Patient's Name _____ Home Phone _____

Birthdate _____ M/F _____ Cell Phone _____

School _____ Employer _____

Address _____

Patient's Dentist _____ Patient's Physician _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____

Address _____

Home Phone _____ Work Phone _____

Employer _____ Cell Phone _____

E-mail address _____

Spouse's Name _____

Home Phone _____ Work Phone _____

Employer _____ Cell Phone _____

Orthodontic Insurance Information

Primary Insurance Company _____

Insured's Name _____ Birthdate _____

Employer _____ SS or ID # _____

Insurance Co. Address _____

Insurance Co. Phone # _____ Group/Local # _____

Secondary Insurance Company _____

Insured's Name _____ Birthdate _____

Employer _____ SS or ID # _____

Insurance Co. Address _____

Insurance Co. Phone # _____ Group/Local # _____

Continued on back…

Medical History

Are you currently under a doctor's care? ◯ Yes ◯ No If yes, Doctor's name: _____ Last examination date: _____

Have you had any surgery, hospitalizations or serious health issues. ◯ Yes ◯ No (Please explain:)

_____

_____

Have you taken any medication in the last six months? ◯ Yes ◯ No (Please list ALL medications including prescriptions, herbal supplements and vitamins and why you are taking them - please use additional paper if needed): _____

_____

Do you have any allergies? ◯ Yes ◯ No

Please list your allergies: _____

Do you smoke? ◯ Yes ◯ No Check all that apply: ☐ pipe ☐ cigar ☐ cigarettes How much? _____ For how long? _____

Have you or any member of your family had a bad experience with a general or local anesthetic? ◯ Yes ◯ No

*Have you had any of the following? (please **check box** to indicate a "yes" answer)*

☐ ADHD	☐ autism	☐ bleeding disorder	☐ diabetes	☐ heart murmur	☐ sinus problems
☐ anemia	☐ cancer	☐ eating disorder	☐ heart problem	☐ lung disease	☐ smokers cough
☐ angina pectoris	☐ chronic bronchitis	☐ emphysema excessive	☐ hepatitis	☐ pneumonia	☐ stroke
☐ arthritis	☐ cold sores/fever blisters	☐ bruising glaucoma	☐ IBS	☐ porphyria	☐ ulcer
☐ asthma	☐ colitis	☐ glomerulonephritis	☐ increased blood pressure	☐ rheumatic fever	☐ Von Willibrand
☐ anxiety disorder	☐ decreased blood pressure	heart attack	☐ jaundice	☐ scarlet fever	☐ venereal disease
☐ bleeding tendency	☐ depressive disorder		☐ kidney disease	☐ seizure disorder	☐ endometriosis
☐ polycystic ovarian disease					

FEMALES ONLY:

Do you have a menstrual cycle? ◯ Yes ◯ No Are you or could you be pregnant? ◯ Yes ◯ No How long? _____

Are you using or have you ever used the birth control pill? ◯ Yes ◯ No If yes, brand of birth control have or are you taking? _____

Orthodontic History

Have you consulted with another orthodontist? ◯ Yes ◯ No Have you worn braces in the past? ◯ Yes ◯ No

If you have previously seen an orthodontist, were any of the following discussed? (check all that apply)

☐ Extraction of upper teeth?
☐ Elastics (rubber bands)?
☐ Roof of the mouth appliance?
☐ Extraction of lower teeth?
☐ Corrective Jaw Surgery?
☐ Headgear?
☐ Functional appliance?

What is the reason for your visit **today**? **(Check all that apply)**: ☐ bite correction ☐ cleft lip & palate ☐ dental/smile esthetics ☐ facial esthetics ☐ facial pain treatment ☐ obstructive sleep apnea ☐ speech improvement ☐ TMJ treatment ☐ other: _____

What is your impression of the type of treatment needed?: ☐ expansion ☐ extractions ☐ full braces ☐ interceptive treatment ☐ limited braces ☐ jaw surgery ☐ unaware ☐ other: _____

Please list any special concerns or provide any additional information that you feel would be beneficial to share with the doctor:

_____

_____

_____

Signature_____ Date_____