Sletten & Brettin Orthodontics
Specialists in Orthodontics and Dentofacial Orthopedics
6303 Osgood Avenue N, Suite 205, Stillwater, MN 55082 • Phone 651-439-3350
400 2nd Street S, Suite 230, Hudson, WI • 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 # _____

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Medical History

Are you currently under a doctor's care? ..... Y ___ N ___

Doctor's name _____ last examination date _____

Have you had a heart, blood vessel, lung, kidney, or joint replacement surgery? ..... Y ___ N ___
Have you been hospitalized in the past 2 years? ..... Y ___ N ___

why? _____

Have you taken any medication in the last six months? (circle) high blood pressure, insulin, heart, tranquilizers, blood thinner, ... Y ___ N ___
steroids, aspirin, asthma, Parkinson's, DIET medication, anti-depressents, herbal supplements, or other medications?

list all medications _____

Do you have any allergies? (circle) drugs, aspirin, codeine, penicillin, keflex? ..... Y ___ N ___

other _____

Do you smoke (pipe, cigar, cigarettes)? packs per day _____ ? for how long _____ ? ..... Y ___ N ___
Have you or any member of your family had a bad experience with a general or local anesthetic? ..... Y ___ N ___

Have you had any of the following? (please circle 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	hepatitis	pneumonia	stroke
arthritis	cold sores/fever blisters	excessive bruising	IBS	porphyria	ulcer
asthma	colitis	glaucoma	increased blood pressure	rheumatic fever	Von Willibrand
anxiety disorder	decreased blood pressure	glomerulonephritis	jaundice	scarlet fever	venereal disease
bleeding tendency	depressive disorder	heart attack	kidney disease	seizure disorder	endometriosis
polycystic ovarian disease					

Females only
Are you or could you be pregnant? months _____ ? ..... Y ___ N ___
Do you have a menstrual cycle? ..... Y ___ N ___
Are you using or have you ever used the birth control pill? ..... Y ___ N ___

Which brand of birth control pill are you taking or have taken? _____

Orthodontic History

Have you worn braces in the past? ..... Y ___ N ___

Have you consulted with another orthodontist? ..... Y ___ N ___

If yes, were any of the following discussed?:

Extraction of upper teeth? ..... Y ___ N ___
Elastics (rubber bands)? ..... Y ___ N ___
Roof of the mouth appliance? ..... Y ___ N ___
Corrective Jaw Surgery? ..... Y ___ N ___

Extraction of lower teeth? ..... Y ___ N ___
Headgear? ..... Y ___ N ___
Functional appliance? ..... Y ___ N ___

What is the reason for your visit?: ( ) bite correction ( ) dental/smile esthetics ( ) facial esthetics( ) TMJ treatment
( ) facial pain treatment ( ) speech improvement ( ) obstructive sleep apnea ( ) cleft lip & palate ( ) _____

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

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

_____

_____

_____

Signature_____ Date_____