KIMBROUGH
ORTHODONTICS

Date: _____

WILLIAM A. KIMBROUGH, D.D.S., M.S., INC.
AMERICAN BOARD OF ORTHODONTICS CERTIFIED
1542 Green Oak Place
Kingwood, TX 77339
Tel. 281-358-8551
Fax. 281-358-0230

1 BEGIN HERE: PATIENT INFORMATION

Name: _____ Phone: (____) _____ Birthday: _____
First MI Last Nickname

Address: _____ Height: _____ Age: _____

City: _____ State: _____ Zip: _____ Weight: _____ Sex: _____

2 GENERAL INFORMATION

FATHER or SELF or GUARDIAN INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Email: _____

EMPLOYER/INSURANCE INFORMATION

Employer's Name: _____

Number of Years Employed: _____ Occupation: _____

Dental Insurance Name: _____

Orthodontic Coverage? Yes ____ No _____

SS# or ID#: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: (_____) _____ ext. _____

MOTHER or SPOUSE INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work: (____) _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Email: _____

EMPLOYER/INSURANCE INFORMATION

Employer's Name: _____

Number of Years Employed: _____ Occupation: _____

Dental Insurance Name: _____

Orthodontic Coverage? Yes ____ No _____

SS# or ID#: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

Insurance Phone: (_____) _____ ext. _____

3 OTHER INFORMATION

Who is the responsible party: _____ Has a dentist or doctor referred you to us? (please circle one) **Yes / No**

If so, who may we thank? Name: _____ Address: _____

If not, how did you hear about us? (please circle one) **Google search / Friend / Social media / Other (please specify)** _____

Dentist Name: _____ Dentist Address: _____

School Name: _____ Grade: _____ Sports or Hobbies: _____

Number of Brothers: _____ Ages: _____ Number of Sisters: _____ Ages: _____

4 MEDICAL INFORMATION

	YES	NO
Frequent or Severe Headaches:		
Any Heart Disease:		
Any Sinus or Respiratory Disease:		
Any Blood Disease:		
Any Liver Disease:		
Any Thyroid Disease:		
Any Kidney Disease:		
H.I.V. Positive:		
Any Venereal Disease:		
Any Intestinal Disease:		
Any Bone Disease:		
Any Nervous /Emotional Problems:		
Any High or Low Blood Pressure:		
Any Endocrine Problems:		
Any Problems with Wounds Healing:		
Any Tumors or Cancer:		
Tonsilitis Frequent Sore Throats:		
Any Joint Problems:		

	YES	NO
Rheumatic/Yellow/Scarlet Fever:		
Acquired Immune Deficiency Syndrome:		
Is Patient Under Medical Care:		
Rheumatism or Arthritis:		
Is the Patient taking any Medications:		
A History of Fainting or Dizziness:		
Does the Patient have a Drug Addiction:		
Is the Patient Pregnant at this Time:		
Measles/Mumps/Chicken Pox:		
Does the Patient Smoke:		
Has the Patient ever had Fever Blisters:		
Is Height & Weight Normal for Age:		
Is the Patient in Good Health:		
Has the Patient had a Physical this Year:		
Has the Patient Reached Puberty:		
If Male, Begun to Shave:		
If Female, Begun to Menstruate:		

	YES	NO
Heart Murmur:		
Mononucleosis:		
Hepatitis:		
Polio:		
Diabetes:		
Anemia:		
Hemophilia:		
Emphysema:		
Epilepsy:		

	YES	NO
Asthma or Hay Fever:		
Tuberculosis:		
Any Broken Bones:		
Prolonged Bleeding:		
Yellow Jaundice:		
Radiation Therapy:		
Chemical Therapy:		
Blood Transfusions:		
Latex Allergy:		

Is the Patient Allergic to Anything: _____
What: _____

Are you aware of any other disease, condition, or problem not listed above that we should know about:
If Yes, What: _____

Any Unusual Reactions to Any of the Following:
Aspirin: _____ Sulfa Drugs: _____
Barbiturates: _____ Other Medications: _____
Penicillin: _____

List Any Medications Currently Taking: _____

Please Explain: _____

5 DENTAL HISTORY

	Yes	No
Has the Patient Seen a General Dentist in the Last Year:		
Any Pain, Clicking or Discomfort In or Near the Ears:		
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident:		
Have You Been Informed of Missing or Extra Permanent Teeth:		
Are You Aware of Any "Gum" Problems:		
Have the Patient's Tonsils or Adenoids Been Removed:		
Do You Feel the Patient can Benefit From Orthodontic Treatment:		
Is the Patient Happy with Their "SMILE":		
Does the Patient Want to Improve Their "SMILE" and "BITE":		
Would the Patient Mind Wearing "BRACES":		
When are Patient's Teeth Brushed:		
After Breakfast:		
After Lunch:		
After Dinner:		
Before Bed:		

Does the Patient Have or Ever Had Any of the Following Habits:

	Yes	No
Cheek, Tongue or Lip Chewing:		
Thumb Sucking:		
Mouth Breathing:		
Finger Nail Biting:		

	Yes	No
Clenching Teeth:		
Tongue Thrusting:		
Grind Teeth:		
Speech Problems:		

Has the Patient Been Examined by an Orthodontist Before: _____
If Yes, When: _____
Have Other Members of the Family had Orthodontic Treatment: _____
If Yes , Were You Happy With the Results: _____

If No, Why: _____

Patient's Attitude Toward Braces:
Eagerness: _____
Complacency: _____
Willingness: _____
Antagonism: _____

Who First Noticed the Orthodontic Problem:
Parent: _____
Patient: _____
Dentist: _____
Other: _____

In Your Own Words What is the Orthodontic Problem: _____

What Would you Like Orthodontic Treatment to Accomplish: _____

I understand that when appropriate, credit bureau reports may be obtained.

Patient Signature **Date** **Parent Signature**

6 FOR OFFICE USE ONLY