

PATIENT INFORMATION

Today's Date: _____ Birthdate: _____
 Age: _____
 Patient's name: _____
Last First Middle
 Prefers to be called: _____
 Address: _____
Street
City State Zip
 Home Phone: (____) _____
 Parents marital status: (single, married, divorced)
 If patient is a minor give parent's or guardian's name:

 List other family members seen by us: _____

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

PRIMARY ORTHODONTIC-DENTAL INSURANCE

Insurance Company: _____
 Address: _____
Street
City State Zip
 Phone: (____) _____
 Group / Policy No: _____
 Local No: _____
 Insured Name: _____
Last First Middle
 Relationship to Patient: _____
 Insured Birthdate: _____
 Insured Employer: _____
 Insured SSN: _____
Orthodontic Coverage: YES NO

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle
 Residence: _____
Street
City State Zip
 Mailing Address: _____
Street
City State Zip
 How long at this address? _____
 Home Phone: (____) _____
 Work Phone: (____) _____
 SSN: _____
 Birthdate: _____
 Relationship to Patient: _____
 Employer: _____
 Occupation: _____
 Years Employed: _____

SECONDARY ORTHODONTIC-DENTAL INSURANCE

Insurance Company: _____
 Address: _____
Street
City State Zip
 Phone: (____) _____
 Group / Policy No: _____
 Local No: _____
 Insured Name: _____
Last First Middle
 Relationship to Patient: _____
 Insured Birthdate: _____
 Insured Employer: _____
 Insured SSN: _____
Orthodontic Coverage: YES NO

SPOUSE INFORMATION

Spouse's Name: _____
Last First Middle
 Relationship to Patient: _____
 Employer: _____
 Occupation: _____
 Years Employed: _____
 SSN: _____
 Birthdate: _____
 Work Phone: (____) _____

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you:

Last First Middle
 Relationship to Patient: _____
 Phone: (____) _____
I understand that where appropriate, credit bureau reports may be obtained.
 Signature _____

MEDICAL HISTORY

Name: _____

Age: _____

Male Female

Have you ever been treated for any of the following? (Please Circle):

Diabetes

Tuberculosis

Endocrine/Thyroid

High Blood Pressure

Anemia

Prolonged Bleeding

Heart Trouble

Epilepsy

Liver Disorder

Rheumatic Fever

Heart Murmur

Asthma

Fainting/Dizziness

Bone Disorder

Kidney Disorder

Hepatitis

Psychological Disorder

Arthritis

Venereal Disease

Cancer/Malignancy

Hay Fever

List any other Medical Conditions: _____

YES NO

- ___ ___ Are you in good health?
___ ___ Is there any history of major illness?
___ ___ Any drugs or medications currently in use? What? _____
___ ___ Are there any drug sensitivities? List: _____
___ ___ Have you ever had surgery? What type? _____
___ ___ Do you have the tendency for cold sores, sore throats, or ear infections?
___ ___ Are you sensitive to Latex?
___ ___ Do you smoke?

DENTAL HISTORY

Name of current general dentist: _____ Date of last exam: _____

Address: _____

YES NO

- ___ ___ Have there been any injuries to the face, mouth, or teeth?
___ ___ Have you ever had speech therapy?
___ ___ Are you a mouth breather?
___ ___ Were you or are you currently a thumb sucker?
___ ___ Have you had an adverse reaction to dental anesthesia?
___ ___ Have you been treated for gum disease?
___ ___ Have you had previous orthodontic treatment or consultation? When? _____
___ ___ Do you play any musical instrument? What type? _____
___ ___ Do you clench or grind your teeth?
___ ___ Does your jaw click or pop?
___ ___ Is there difficulty opening wide?
___ ___ Does your jaw ever stick so you can't open/close?
___ ___ Does it hurt to chew?
___ ___ Is there pain in front of your ears?
___ ___ Is there cheek or temple pain?
___ ___ Do you suffer from headaches?
___ ___ Do you have neck or shoulder pain?
___ ___ **What are your concerns about your teeth or jaw?** _____

I have completed this form to the best of my knowledge and it is my responsibility to inform this office of any changes in the medical status:

Signature Guardian / Responsible Party: _____ Date: _____

Reviewed By: _____ Date: _____