Patient Information

Patient's Name _____
Last First Name Prefer to be Called Middle Init.

Home Phone _____ Birthdate _____ Sex _____ Social Security # _____

Address _____
Street City State Zip

If patient is a minor, give parent's or guardian's name _____

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

Other family members previously or currently in our care? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____ How long? _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Orthodontic Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Contract # _____

Insurance Co. Address _____

Do you have dual coverage? Yes ❑ No ❑ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Contract # _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____

Please complete the other side.

MEDICAL HISTORY

Are you in good health? _____yes _____no Explain: _____

Any major or unusual illnesses? _____yes _____no Explain: _____

Currently being treated by a physician? _____yes _____no Reason: _____

Currently taking medication? _____yes _____no Reason: _____

Allergies? _____yes _____no List: _____

Drug sensitivity? _____yes _____no List: _____

Please check if you have or have had any of the following:

Yes	No		Yes	No		Yes	No	
_____	_____	Anemia	_____	_____	Heart Problems	_____	_____	Frequent Colds or Flu
_____	_____	Blood Disease	_____	_____	Tuberculosis	_____	_____	Tonsillitis
_____	_____	Prolonged Bleeding	_____	_____	Diabetes	_____	_____	Tonsils Removed: Age: _____
_____	_____	Jaundice	_____	_____	Endocrine Problems	_____	_____	Adenoids Removed: Age: _____
_____	_____	Rheumatic Fever	_____	_____	Bone Disorders	_____	_____	Asthma
_____	_____	Scarlet Fever	_____	_____	Epilepsy	_____	_____	Mouthbreathing: While awake ____
_____	_____	Hepatitis	_____	_____	Fever Blisters			While asleep ____
_____	_____	Glaucoma						

DENTAL HISTORY

Yes	No	
_____	_____	Have you ever had any severe head or face injuries? Explain: _____
_____	_____	Have you had a history of thumb sucking or finger sucking? _____, Stopped? _____ When? _____
_____	_____	Do you play any musical (wind) instruments? _____ What? _____
_____	_____	Have you consulted an orthodontist previously? _____
_____	_____	Have you had any previous orthodontic treatment? _____
_____	_____	Have any family members had orthodontic treatment? _____
_____	_____	Do you normally take antibiotics prior to dental cleaning? _____
		When was your last dental cleaning? _____
_____	_____	Previous periodontal (gum) treatment? When? _____ Where? _____

Please check if there is a history of:

_____ Clenching Teeth ____ Headaches (more than normal) _____ Jaw Joint Popping

_____ Grinding Teeth ____ Jaw Joint Soreness _____ Ringing in the Ears

_____ Muscular Soreness around Head and Neck ____ Jaw Joint Clicking

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Is there any other information that may be helpful? _____

_____ Date: _____

Updates (date and initial) _____ _____ _____ _____ _____

Additional Information

_____

_____

_____

_____

_____