PLEASE COMPLETE IN FULL

PATIENT INFORMATION

Date _____ Name you want to be called _____

Patient's Name _____ Patient's Sex _____ Patient's Age _____
Last First Middle

Address _____

Home Phone (_____) _____ Birthdate _____ Patient Ht. _____ Patient Wt. _____

Social Security # _____ Email _____

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

Names of other family members we have treated _____

Who may we thank for referring you to our office? _____ Patient's Dentist _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Social Security # _____ Relationship to Patient _____

Employer _____ Occupation _____

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

Social Security # _____ Work Phone (_____) _____

Employer _____ Occupation _____

ORTHODONTIC INSURANCE INFORMATION ONLY

MUST BE FILLED OUT COMPLETELY TO PROCESS CLAIMS

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insured's Employer _____

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

Insured's Name _____ Birthdate _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____

Insurance Company Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone (_____) _____

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

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

Updates (date & initial) _____ _____ _____ _____ _____

All information is confidential.

MEDICAL HISTORY

Has the patient ever been treated for any of the following:

	YES	NO		YES	NO		YES	NO	?
DIABETES	☐	☐	*TUBERCULOSIS*	☐	☐	*ENDOCRINE OR THYROID*	☐	☐	☐
IMMUNE DEFICIENCY	☐	☐	*ANEMIA*	☐	☐	*PROLONGED BLEEDING*	☐	☐	
HEART MURMUR	☐	☐	*EPILEPSY*	☐	☐	*HEPATITIS*	☐	☐	
RHEUMATIC FEVER	☐	☐	*ASTHMA*	☐	☐	*FAINTING OR DIZZINESS*	☐	☐	
ARTHRITIS	☐	☐	*KIDNEY INVOLVEMENT*	☐	☐	*NERVOUS DISORDERS*	☐	☐	
OSTEOPOROSIS	☐	☐	*BLOOD PRESSURE (HIGH/LOW)*	☐	☐	*HIV*	☐	☐	

	YES	NO	?
Is the patient in good health?	☐	☐	☐
Do you smoke or use tobacco?	☐	☐	☐
List any drugs or medications now being taken. Give reasons.	☐	☐	☐
Does the patient have any history of major illness? Explain.	☐	☐	☐
Any drug allergies? If so, list.	☐	☐	☐
Does the patient wear contact lenses?	☐	☐	☐
Have tonsils and adenoids been removed? If yes, at what age?	☐	☐	☐
Growth in the past 6 months _____ Has patient reached puberty?	☐	☐	☐
Females only: Are you pregnant?	☐	☐	☐

Height: Patient's _____ Mother's _____ Father's _____ Patient's Weight _____

Patient's Physician _____ Date last seen _____

DENTAL HISTORY

	YES	NO	?
When was the last time your teeth were cleaned?			
How often do you brush your teeth? _____ Floss your teeth?			
Have there been any injuries to the face, mouth or teeth?	☐	☐	☐
Has the patient ever sucked a thumb or finger? If yes, until what age?	☐	☐	☐
Does the patient play a musical instrument?	☐	☐	☐
Does the patient have any clicking or discomfort in jaw joints near ears?	☐	☐	☐
Have you been informed of any missing or extra permanent teeth?	☐	☐	☐
Has the patient had any previous orthodontic examinations?	☐	☐	☐
Does the patient clench or grind his/her teeth?	☐	☐	☐
Is the patient especially apprehensive toward dental visits?	☐	☐	☐
Does the patient have any emotional or learning problems which may affect orthodontic treatment?	☐	☐	☐

Please list any additional health history and personal information that could be helpful for us to know.

_____

_____

I certify that the above information is accurate to the best of my knowledge. *Signature:* _____

Date: _____ *Relationship:* _____