PATIENT INFORMATION

Date_____ Birthdate _____ Age _____ M ◯ F ◯

Patient's Name_____
Last First Middle Nickname

Address_____Phone_____
Street City State Zip

Social Security #_____School _____ Grade_____

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

List the names and ages of brothers and sisters or siblings_____

How did you hear about our office or who referred you?_____

RESPONSIBLE PARTY INFORMATION

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address? _____Home Phone_____Work Phone_____

E-Mail Address _____Cell Number _____

Previous Address (if less than 3 yrs)_____Years_____
Street City State Zip at this address

Social Security #_____Birthdate_____Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Spouse's Name_____Relationship to Patient_____
Last First Middle

Mailing Address_____
Street City State Zip

Social Security #_____Birthdate_____Work Phone_____Cell Phone_____

Employer_____Occupation_____No. Years Employed_____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name_____ Social Security #_____

Mailing Address_____ Date of Birth _____

Insurance Company_____ Member ID No._____Group No._____

Insurance Co. Address_____ Phone_____
Street City State Zip

Insured's Employer_____Address_____

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

Secondary Insured's Name_____ Social Security #_____

Mailing Address_____ Date of Birth _____

Insurance Company_____ Group No. _____Local No._____

Insurance Co. Address_____ Phone_____
Street City State Zip

Insured's Employer _____Address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____Relationship_____

Residence_____Phone_____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parents signature if minor) _____

Updates (Date & Initial)_____/_____/_____/_____/_____

CONFIDENTIAL (for record and pretreatment evaluation)

PATIENT MEDICAL HISTORY

Physician's Name_____ Approximate date of last physical exam_____

Has patient ever been under extended care of a physician? ☐ Yes ☐ No If yes, please explain_____

_____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Anemia	☐ Excessive Bleeding	☐ Pain in Jaw Joints
☐ Asthma	☐ Heart Problems	☐ Rheumatic Fever
☐ Cold Sores or Fever Blisters	☐ Hepatitis	☐ Sinus Problems
☐ Diabetes	☐ HIV Positive (AIDS)	☐ Tonsillitis
☐ Drug Addiction	☐ Nervous Disorders	☐ Tuberculosis
☐ Endocrine Problems		

Does patient gag easily? ☐ Yes ☐ No

Does patient wear contact lenses? ☐ Yes ☐ No

Does patient have frequent ear infections? ☐ Yes ☐ No

Have tonsils and adenoids been removed? ☐ Yes ☐ No At what age?_____

Women: Are you pregnant? ☐ Yes ☐ No

Are medications now being taken ? ☐ Yes ☐ No Please list type and reason _____

_____

Does patient have any allergies to: ◯ Yes ◯ No If yes, please list: _____

foods, medications, environmental (ie., hay fever)

PATIENT DENTAL HISTORY

Dentist's Name_____ Approximate date of last dental exam _____

Have there ever been any injuries to the face, mouth, or teeth? ◯ Yes ◯ No _____

Has patient ever sucked their fingers or thumb? ◯ Yes ◯ No Until what age?_____

Does patient have any speech problems? ◯ Yes ◯ No _____

Is patient a mouth breather while asleep? ◯ Yes ◯ No

Is patient a mouth breather while awake? ◯ Yes ◯ No

Have you been informed of any extra or missing permanent teeth? ◯ Yes ◯ No_____

Has patient ever had a previous orthodontist exam? ◯ Yes ◯ No _____

Have any family members had orthodontic treatment? ◯ Yes ◯ No _____

Is there pain in the jaw joint? If Yes……. ☐ Right ☐ Left When did this begin_____

Is there any popping or cracking of the jaw joint? If Yes……. ☐ Right ☐ Left When did this begin_____

Does patient clench or grind? If Yes……. ☐ Night ☐ Day When did this begin_____

Does patient have headaches? ◯ Yes ◯ No

Frequency_____ Location_____

What is the chief concern that brought you to our office?_____

_____

_____

_____