Patient Information

Date_____

Patient's name_____ M / F

Last First Middle Initial Nickname Age

Address _____

Street City Zip

Home Phone_____ Birthdate_____ Social Security # _____

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

Email (parent's if patient a minor) _____

Responsible Party Information

Name_____Marital Status_____

Last First Middle

Residence _____

Street City Zip

Mailing Address_____

Street City Zip

How long have you lived at this address_____ Home phone _____Cell phone_____

Previous Address (If less than 3 years) _____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ Work Phone _____

Spouse's Name_____ Relationship to Patient _____

Employer_____ Occupation_____ Work Phone _____

Social Security # _____Birthdate _____

Dental Insurance Information

Insured's Name_____ SS # or ID _____Birthdate_____

Insured's Employer_____

Insurance Company_____Group#_____

Insurance Co Address_____Phone#_____

Do you have orthodontic coverage? Yes_____ No____ Do you have dual coverage? Yes_____ No_____

If yes to dual coverage, please fill out the following:

Insured's Name_____ SS # or ID # _____Birth date_____

Insured's Employer_____

Insurance Company_____Group#_____

Insurance Co Address_____Phone# _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication, food, metal or latex? _____
Yes No Do you have a history of a major illness or have you had any major operations? _____
Yes No Are you prone to get to colds, sore throats or ear infections? _____
Yes No Have you had your tonsils or adenoids removed? _____
Yes No Have you ever been involved in a serious accident? _____

Female Patients:

Yes No Are you pregnant? _____
Yes No Has menstruation started? _____

Circle any of the medical conditions below that you have had or currently have:

Abnormal or Prolonged Bleeding	Heart Problem	Hepatitis/Liver Problem	Neurological Disorder
Anemia	Heart Murmur	Herpes	Epilepsy
Hemophilia	Rheumatic Fever	HIV / AIDS	Mental Health Problem
Arthritis	High Blood Pressure	Kidney Problem	Eating Disorder-Bulimia/Anorexia
Other Bone Disorders/Osteoporosis	Tuberculosis	Asthma or Hay fever	Tumor or Cancer
Artificial joint/Valve/Pacemaker	Diabetes	Pneumonia	Radiation/Chemotherapy
Congenital Heart Defect	Gastrointestinal Disorder	Dizziness	Growth Problem
			Sinus Problem

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

What concerns you most about your teeth? _____
Dentist _____ Date of last visit _____

Yes No Were you referred by your General Dentist?
If not, how did you hear about our office? _____
Yes No Have other family members received orthodontic care in our office? Who? _____
Yes No Have you ever seen another orthodontist? If yes, who and When? _____
_____
Yes No Are you presently in any dental pain? _____
Yes No Have you ever experienced any unfavorable reaction to dentistry? _____
Yes No Have there been any injuries to face, mouth or teeth? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Have you ever been told you have periodontal disease? _____
Yes No Do you currently have or do you have a history of any type of thumb or finger sucking habit? _____
Yes No Do you have difficulty breathing through your nose? _____
Yes No Have you been told you snore at night? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? _____
Yes No Are you aware of your jaw clicking or popping? _____
Yes No Are you aware of clenching your teeth during the day? _____
Yes No Have you ever been told that you grind your teeth? _____
Yes No Do you have “tension” headaches? _____
Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Are you aware that some orthodontic appointments will be during school/work hours? _____

Children:

What school do you attend? _____ Grade _____
Please list some of your hobbies, sports, other interests _____

What is your child’s attitude toward receiving orthodontic treatment _____

Patient or Legal Guardian Signature: _____ Date: _____

Doctor Signature: _____ Date: _____