Patient Biographical Information

Date: _____________

First Name: ___________________ Middle Initial: ______ Last Name: ___________________________________

Nickname: ____________________ Age: _____ Birthdate: ________________ Gender: Male____ Female _____

Address: _______________________________________ City: _____________ State: ___________ Zip: _______

Home Phone #: ________________Patient Cell: __________________ Patient Email: ______________________

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

Who does the patient live with? ____

Emergency Contact: _________________Primary phone #: _____________ Relationship to Patient: ___________

Emergency contact email: ____

Please list the names of any family or friends currently in the practice: ____________________________________

Who may we thank for referring you to our practice? ____

Is there any orthodontic or dental insurance for the patient? Yes ___ No ___
If yes, please see attached form.

Confidential Financial Party Information

Patient/Parent/Guardian #1- Name of patient/parent or legal guardian who will be responsible for the account:

First Name: ________________ Middle Initial: ____ Last Name: __________________ Relationship to Patient: _____________

☐ *Check if address is the same as the patient's; if not, complete address below*

Address: ____ City: _________________ State: ____________ Zip: ____________

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

How long at this address? ________ If less than 2 years, previous address: ____

Phone Numbers: Primary: _____________________ Cell: ______________________ Work: _________________________

Email: _____________________________________ DOB: ____

Occupation: _________________________ Employer: ___________________________________ How Long? ____________

Parent/Guardian #2:

First Name: _________________ Middle Initial: ____ Last Name: _________________ Relationship to Patient: _____________

☐ *Check if address is the same as the patient's; if not, complete address below*

Address: ______________________________________ City: ________________ State: ___________ Zip: ____________

Phone Numbers: Primary: ____________________ Cell: ____________________ Work: ______________________

Email: ____________________________________ DOB: ____

Occupation: __________________________ Employer: __________________________________ How Long? ____________

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 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: ______________________

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