

PATIENT INFORMATION

Date _____ Age _____ Birth Date _____ Sex _____
 Patient's Name
 Last _____ First _____ MI _____ Preferred Name _____
 Home Address
 Street _____ City _____ State _____ ZIP _____ Home Phone _____
 Driver's License # (if applicable) _____ Social Security # _____
 Whom may we thank for recommending our services? _____
 Names and ages of children in family _____

 Have any been seen in our office? No Yes: _____

RESPONSIBLE PARTY INFORMATION (If patient is a minor, provide parent or legal guardian information.)

Name
 Last _____ First _____ MI _____ Preferred Name _____
 Marital Status Single Married Divorced Separated Widowed Driver's License # _____
 Mailing Address _____
 How long at this address? _____ years Previous Address (if less than 3 years) _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Preferred number _____
 Email addresses for appointment reminders, etc. _____
 Social Security # _____ Birth Date _____ Relationship to patient _____
 Employer _____ Occupation _____ Number of years employed _____
 Spouse's Name _____ Relationship to patient _____
 Social Security # _____ Birth Date _____ Phone _____
 Employer _____ Occupation _____ Number of years employed _____

EMERGENCY CONTACT INFORMATION

Name _____
 Phone Number(s) _____ Relationship to patient _____

PRIMARY DENTAL INSURANCE

Insured's Full Name _____ Birth Date _____
 Social Security # _____ Relationship to patient _____
 Insurance Company _____ Group # _____ Contract # _____
 Insurance Company Address _____
 Does this policy have orthodontic benefits? Yes No Don't Know Insurance Phone # _____
 Insured's Employer _____

SECONDARY DENTAL INSURANCE

Insured's Full Name _____ Birth Date _____
 Social Security # _____ Relationship to patient _____
 Insurance Company _____ Group # _____ Contract # _____
 Insurance Company Address _____
 Does this policy have orthodontic benefits? Yes No Don't Know Insurance Phone # _____
 Insured's Employer _____

GENERAL INFORMATION

What concerns the patient about his/her teeth and jaws? _____
Other family members with similar condition? _____
Who suggested that the patient might need orthodontic treatment? _____
Has the patient ever had any previous orthodontic treatment or consultation? _____
Why did you select our office? _____
What school does the patient attend? _____ Grade? _____
List interests and hobbies. _____

DENTAL HISTORY

Patient's dentist _____ Date of last exam? _____
Remaining recommended dental work? _____
How often does the patient have dental check-ups? _____
Have there been any injuries to the face, mouth or teeth? _____
Has the patient been informed of any missing or extra permanent teeth? _____
Please check any of the following conditions that apply to patient:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Crowns	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Sensitivity to Cold
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Earaches	<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Sensitivity to Hot
<input type="checkbox"/> Bridgework	<input type="checkbox"/> False Teeth	<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Sensitivity to Sweets
<input type="checkbox"/> Broken Fillings	<input type="checkbox"/> Food Between Teeth	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Sensitivity when Biting
<input type="checkbox"/> Clicking/Popping Jaws	<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Partial Dentures	<input type="checkbox"/> Sores/Growth in Mouth

MEDICAL HISTORY

Name of Physician _____ Date of last visit _____
Please list all medications patient is currently taking _____
Allergies _____
(Women) Is patient pregnant? Yes No Nursing? Yes No Taking birth control? Yes No
Does patient have a history of any of the following?

<input type="checkbox"/> AIDS	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cough, Persistent	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Cough Up Blood	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Major Surgery	<input type="checkbox"/> Swelling of Feet
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mitral valve Prolapse	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Back problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever	
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Scarlet Fever	

Other _____
Describe heart problems _____ Does patient require premedication? Yes No

To the best of my knowledge, the two pages of information (front and back) are complete and correct. I give permission for any photographs, x-rays, or study models to be used for displays at scientific presentations and/or publications of a scientific nature or for group purposes to further the art and science of orthodontics. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

Signature of Patient or Parent/Guardian if Patient is a Minor

Date

Printed Name of Patient or Parent/Guardian if Patient is a Minor