## Patient Information

Patient's Name _____
Last First Name Prefer to be Called Middle Init.

Home Phone _____ Birthdate _____ Sex _____ Social Security # _____

Address _____
Street City State Zip

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

Whom may we thank for referring you to our office? _____ General Dentist _____

Family members in or out of orthodontic treatment _____

## Responsible Party Information

Responsible Party or Guardian's Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Email (for appointment reminders) _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____

## Orthodontic Insurance Information

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Insurance Company _____ Contract No. _____ Group No. _____

Insurance Co. Address _____

Subscriber's Employer _____ Subscriber's Birthdate _____

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

Subscriber's Name _____ Subscriber's Soc. Sec. # _____

Insurance Company _____ Contract No. _____ Group No. _____

Insurance Co. Address _____

Subscriber's Employer _____ Subscriber's Birthdate _____

## Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

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

**Please Complete the other side.**

## MEDICAL HISTORY

| | | |
|---|---|---|
| Are you in good health? | ___yes ___no | Explain: _____ |
| Any major or unusual illnesses? | ___yes ___no | Explain: _____ |
| Currently being treated by a physician? | ___yes ___no | Reason: _____ |
| Currently taking medication? | ___yes ___no | Reason: _____ |
| Allergies? | ___yes ___no | List: _____ |
| Drug sensitivity? | ___yes ___no | List: _____ |

Please check if you have or have had any of the following:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Anaemia | ___ | ___ | Heart Problems | ___ | ___ | Frequent Colds or Flu |
| ___ | ___ | Blood Disease | ___ | ___ | Tuberculosis | ___ | ___ | Tonsillitis |
| ___ | ___ | Prolonged Bleeding | ___ | ___ | Diabetes | ___ | ___ | Adenitis |
| ___ | ___ | Jaundice | ___ | ___ | Endocrine Problems | ___ | ___ | Tonsils Removed: Age: _____ |
| ___ | ___ | Rheumatic Fever | ___ | ___ | Bone Disorders | ___ | ___ | Adenoids Removed: Age: _____ |
| ___ | ___ | Scarlet Fever | ___ | ___ | Epilepsy | ___ | ___ | Asthma |
| ___ | ___ | Hepatitis | ___ | ___ | Herpes | ___ | ___ | Mouthbreathing: While awake _____ |
| ___ | ___ | Are you in a risk group for Aids? | | | | | | While asleep _____ |
| ___ | ___ | Glaucoma | | | | | | |

## DENTAL HISTORY

| Yes | No | |
|---|---|---|
| ___ | ___ | Have you ever had any severe head or face injuries? Explain: _____ |
| ___ | ___ | Have you had a history of thumb sucking or finger sucking? _____ Stopped? _____ When? _____ |
| ___ | ___ | Do you play any musical (wind) instruments? _____ What? _____ |
| ___ | ___ | Have you consulted an orthodontist previously? _____ |
| ___ | ___ | Have you had any previous orthodontic treatment? _____ |
| ___ | ___ | Have any family members had orthodontic treatment? _____ |

Please check if there is a history of:

| | | |
|---|---|---|
| ___Clenching Teeth | ___Headaches (more than normal) | ___Jaw Joint Popping |
| ___Grinding Teeth | ___Jaw Joint Soreness | ___Ringing in the Ears |
| ___Muscular Soreness around Head and Neck | ___Jaw Joint Clicking | |

What do you think is your orthodontic problem? _____

What do you hope orthodontics will accomplish? _____

Do you have any other concerns regarding your facial appearance? _____

Is there any other information that may be helpful? _____

_____ Date: _____

Updates (date and initial) _____ _____ _____ _____ _____ _____

Additional Information

_____

_____

_____

_____

_____