

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
 Any major or unusual illnesses? yes no
 Currently being treated by a physician? yes no
 Currently taking medication? yes no
 Allergies? yes no
 Drug sensitivity? yes no

Explain: _____
 Explain: _____
 Reason: _____
 Reason: _____
 List: _____
 List: _____

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

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

DENTAL HISTORY

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any severe head or face injuries? Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a history of thumb sucking or finger sucking? _____ Stopped? _____ When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you play any musical (wind) instruments? _____ What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you consulted an orthodontist previously? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any previous orthodontic treatment? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have any family members had orthodontic treatment? _____

Please check if there is a history of:

<input type="checkbox"/> Clenching Teeth	<input type="checkbox"/> Headaches (more than normal)	<input type="checkbox"/> Jaw Joint Popping
<input type="checkbox"/> Grinding Teeth	<input type="checkbox"/> Jaw Joint Soreness	<input type="checkbox"/> Ringing in the Ears
<input type="checkbox"/> Muscular Soreness around Head and Neck	<input type="checkbox"/> 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
