



Patient Information

Date: _____

Patient's Name: _____ **Sex:** _____ **Age:** _____ **Birthdate:** _____

Prefers to be addressed by: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Email address:** _____

Employed by: _____ **Occupation:** _____

Work Phone: _____ **Cell Phone:** _____ **SS#:** _____

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

General Dentist _____ **City** _____

Family Physician _____ **City** _____

Marital Status: Married Single Divorced Separated Widowed

Spouse's Name: _____ **Occupation:** _____ **Work Phone:** _____

Spouse's Employer: _____ **Cell Phone:** _____ **SS#:** _____

Children in Practice Names

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

Name: _____ **DOB:** _____

Responsible Party Information

Person Responsible for Account: Self Spouse Other (State Name): _____

SS#: _____ **Address (If different from above):** _____

Work Phone: _____ **Home Phone:** _____ **Cell Phone:** _____

Dental Insurance Information

Primary Insurance Co.: _____ **ID #:** _____ **Ortho Coverage: Yes NO**

Insured's Name: _____ **SS#:** _____ **Birthdate:** _____ **Gr. #:** _____

Secondary Insurance Co.: _____ **ID #:** _____ **Ortho Coverage: Yes NO**

Insured's Name: _____ **SS#:** _____ **Birthdate:** _____ **Gr. #:** _____

Other Insurance Information: _____

Dental History

Have there been injuries to the face, mouth, or teeth? _____ Yes No

Has the patient ever sucked a thumb or finger? Until what age? _____ Yes No

Does the patient have any speech problems? _____ Yes No

Have you been informed of any missing or extra permanent teeth? _____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

Has either parent or patient had orthodontic treatment? _____ Yes No

Medical History

Is patient in Good health? _____ Yes No

Does patient have a history of major illness? _____ Yes No

If so, what illness? _____

Has patient been under the care of a physician for a major illness? _____ Yes No

ASTHMA	<input type="checkbox"/> Yes <input type="checkbox"/> No	CANCER	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIGH BLOOD PRESSURE	<input type="checkbox"/> Yes <input type="checkbox"/> No
DIABETES	<input type="checkbox"/> Yes <input type="checkbox"/> No	ANEMIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	PROLONGED BLEEDING	<input type="checkbox"/> Yes <input type="checkbox"/> No
PNEUMONIA	<input type="checkbox"/> Yes <input type="checkbox"/> No	EPILEPSY	<input type="checkbox"/> Yes <input type="checkbox"/> No	FAINTING OR DIZZINESS	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEART TROUBLE	<input type="checkbox"/> Yes <input type="checkbox"/> No	NERVOUS DISORDER	<input type="checkbox"/> Yes <input type="checkbox"/> No	LIVER INVOLVEMENT	<input type="checkbox"/> Yes <input type="checkbox"/> No
RHEUMATIC FEVER	<input type="checkbox"/> Yes <input type="checkbox"/> No	TUBERCULOSIS	<input type="checkbox"/> Yes <input type="checkbox"/> No	KIDNEY INVOLVEMENT	<input type="checkbox"/> Yes <input type="checkbox"/> No
BONE DISORDERS	<input type="checkbox"/> Yes <input type="checkbox"/> No	TMJ SYMPTOMS	<input type="checkbox"/> Yes <input type="checkbox"/> No	ENDOCRINE PROBLEMS	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEPATITIS	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC CARE	<input type="checkbox"/> Yes <input type="checkbox"/> No
SNORING	<input type="checkbox"/> Yes <input type="checkbox"/> No	SLEEP APNEA	<input type="checkbox"/> Yes <input type="checkbox"/> No		

List any drugs or medications now being taken. Give reason:

List any drug allergies or drug sensitivities: _____

Other allergies or sensitivities (e.g. latex, metals) _____

Emergency Information

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

This office reserves the right to verify the credit status of potential patients seeking payment terms.

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph, I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. _____ to perform a complete orthodontic evaluation.

Signature of Patient _____ Today's Date _____

Signature of Doctor _____

Doctor's Notes: _____
