



## Patient Information

Date \_\_\_\_\_

**Patient's Name** \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Parent's email address \_\_\_\_\_ Parent's Cell Phone \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

**General Dentist** \_\_\_\_\_ City \_\_\_\_\_

Family Physician \_\_\_\_\_ City \_\_\_\_\_

Siblings: Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

## Responsible Party Information

**Father's Name** \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Person financially responsible for this account Father  Mother

Marital status single  married  divorced  widowed

## Dental Insurance Information

Insured's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ Phone \_\_\_\_\_

Do you have dual coverage?  Yes  No

2<sup>nd</sup> Insured's Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ ID # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co Address \_\_\_\_\_ Phone \_\_\_\_\_

## Medical History

Is patient in Good health? \_\_\_\_\_  Yes  No

Does patient have a history of major illness? \_\_\_\_\_  Yes  No

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	TMD 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		

Have tonsils and adenoids been removed? What age? \_\_\_\_\_  Yes  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) \_\_\_\_\_

## 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

What do you wish to gain from treatment?

## 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 Parent \_\_\_\_\_ Today's Date \_\_\_\_\_

Signature of Doctor \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_

\_\_\_\_\_