

PATIENT INFORMATION

WELCOME TO OUR OFFICE!



Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birth Date _____ Social Security # _____

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

Patient: _____ Responsible Party: _____
Email Address Email Address

RESPONSIBLE PARTY INFORMATION

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 _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birth Date _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Spouse's Employer _____ Occupation _____ No. Years Employed _____

Spouse's Social Security # _____ Spouse's Birth Date _____

INSURANCE INFORMATION

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If Yes, please continue: _____

Insured's Name _____ DOB _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group # _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship to Patient _____

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

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



Why are you or your child seeking orthodontic treatment? (Please be as specific as possible):

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

DENTAL HISTORY

General Dentist: _____ Phone: (____) _____

Address: _____

Date of last dental examination: _____

MEDICAL HISTORY

Family Physician: _____ Phone (____) _____

Address: _____

Is the patient currently under a physician's care? Yes No

If yes, please explain _____

Is the patient taking any medicine at this time? Yes No

If yes, please list _____

Is the patient allergic to any medications? Yes No If yes, please list _____

Does the patient have any other allergies? Yes No If yes, please list _____

Does the patient need to be premedicated (with antibiotics) for routine dental procedures? Yes No

If yes, please specify and give reason for this need: _____

Has the patient ever been hospitalized? Yes No If yes, please explain _____

Females: Is the patient pregnant? Yes No

Does the patient have or has the patient ever had any of the following?

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Injury to head
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Oral Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Radiation or cancer therapy
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils/Adenoid Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Injury to face/teeth/gums

Does the patient have any disease, condition, or problem not listed above? Please explain:

DOES/DID THE PATIENT:

Grind his/her teeth at night? Yes No Brush his/her teeth Often Occasionally Reluctantly

Suck thumb, finger, pacifier? Yes No If yes, what age was the habit discontinued? _____

GROWTH STATUS:

Height: _____ Weight: _____

Females: Has the patient started her menstruation? Yes No

If yes, what age? _____

Males: Has the patient yet undergone voice changes? Yes No

Facial hair growth? Yes No

Signature of the person completing this form: _____

Relationship to the patient: _____ Today's Date: _____