PATIENT INFORMATION

Patient Name _____

Nickname _____ Sex ☐M ☐F

Birthdate _____ Age _____ School _____

Grade _____ Dentist _____

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

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ C _____ W _____ Email _____

Mother's Name _____ Father's Name _____

BILLING PARTY INFORMATION

Name _____ (Select)_____

First Middle Last Marital Status

Residence _____

Street City State Zip

Mailing _____

Street City State Zip

How long at this address? _____ Home Phone _____ C _____ W _____

Birthdate _____ SSN/ID# _____ Drivers license # _____

Relationship to patient _____ Employer / Occupation _____

Spouse's Name _____ Employer _____ Occupation _____ W _____

Spouse's SSN/ID# _____ Spouse's drivers license _____ Birthdate _____

INSURANCE INFORMATION

Insured's Name _____ Insured's SSN/ID# _____ Birthdate _____

Insurance Company _____ Phone Number _____ Group Number _____

Insurance Co. Address _____

Insured's Employer _____ Do you have Dual Coverage ☐ Y ☐N, If yes complete info below

Insured's Name _____ Insured's SSN/ID# _____ Birthdate _____

Insurance Company _____ Phone Number _____ Group Number _____

Insurance Co. Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____

Phone Number _____ Relationship _____

PATIENT DENTAL / MEDICAL HISTORY

Date of last dental exam _____ Date of last dental x-rays _____

Check if you have had any of the following:

☐ Bad breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweets
☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Sensitivity to cold	☐ Sores or growths in your mouth
☐ Breathing through mouth	☐ Suck thumb or fingers	☐ Teased about teeth
☐ Speech problems	☐ Missing teeth	☐ Surgery to repair cleft lip/palate

Have you had a previous orthodontic consultation?	☐ YES	☐ NO	
Would patient mind wearing braces?	☐ YES	☐ NO	
Would patient mind wearing headgear?	☐ YES	☐ NO	
Is patient concerned about their appearance?	☐ YES	☐ NO	
Has patient ever experienced TMJ/Joint problems?	☐ YES	☐ NO	
Have any other family members wore braces before?	☐ YES	☐ NO	Whom? _____
Has a dentist ever placed a retainer or space maintainer?	☐ YES	☐ NO	
Have any primary/permanent teeth been removed by extraction?	☐ YES	☐ NO	
Is patient adopted?	☐ YES	☐ NO	Does he/she know? ☐ YES ☐ NO

How often does patient floss? _____ How often does patient brush? _____

Does patient have any other dental problems not mentioned above? _____

What are the main concerns that you would like orthodontics to accomplish? _____

Physician's Name _____Date of last visit _____

Have you had any serious illnesses or operations? ☐ YES ☐ NO If yes, describe _____

Is patient currently under physician's care? ☐ YES ☐ NO If yes, what for? _____

Is patient currently taking any medication? ☐ YES ☐ NO If yes, what? _____

Does patient have a chronic problem with ☐ Heart ☐ Kidney ☐ Liver ☐ Lung
(Women) Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Has patient ever been diagnosed for any of the following?

☐ Anemia	☐ Diabetes	☐ Epilepsy	☐ Emotional problems
☐ Arthritis, Rheumatism	☐ Fainting	☐ Headaches	☐ Rheumatic fever
☐ Artificial heart valves	☐ Heart murmur	☐ Heart problems	☐ Cerebral palsy
☐ Chemotherapy	☐ Hepatitis	☐ HIV/AIDS	☐ Adenoids removed
☐ Asthma	☐ Jaw pain	☐ Mitral Valve Prolapse	☐ Tonsils removed
☐Blood diseases	☐ Pacemaker	☐ Radiation treatment	☐ Tobacco habit
☐ Cancer	☐ Endocrine	☐ Thyroid problems	☐ Tuberculosis

Any allergies to: ☐ Latex ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in the information.

_____ _____
Signature of parent or guardian Date

I hereby give consent to display orthodontic photographs in this office.

_____ _____
Signature of parent or guardian Date