## Patient Information

*Date

*Last Name | *First Name | *Middle Name

*Street Address | *City | *State | *Zip

*Home Phone | *Birthdate | *Sex: Male | *Social Security #

Marital Status: Single | *If patient is a minor, parent's / guardian's name | Family members already treated

Whom may we thank for referring you to our office? | Patient's General Dentist

## Person Responsible For Account

*Last Name | *First Name | *Middle Name

Mailing Address

*City | *State | *Zip

Email

*How long at this address? | *Home Phone | Work Phone | Cell Phone

*Social Security # | *Birthdate | *Relationship to Patient

Employer | Occupation | No. of years employed

Spouse's Name | Relationship to Patient

Spouse's Employer | Occupation | No. of years employed

Social Security # | Birthdate | Work Phone | Cell Phone

## Insurance Information

Insured's Name | Insured's Birthdate | Social Security #

Insurance Company | Group No.

Insurance Co. Address | Phone

Insured's Employer

Do you have dual coverage? ○ Yes ○ No IF YES:

Insured's Name | Insured's Birthdate | Social Security #

Insurance Company | Group No. | Phone

Insurance Co. Address

Insured's Employer

## Emergency Information

*Name of nearest relative not living with you

*Phone

*Complete Address

## What are the main concerns that you would like orthodontics to address?

*Please describe concerns

*Has the patient ever been evaluated for or had orthodontic treatment before? ◯ Yes ◯ No

*Have there been any injuries to the face, mouth, teeth or chin? ◯ Yes ◯ No

List any musical instruments played

*Have adenoids or tonsils been removed? ◯ Yes ◯ No

*Has the patient been informed of any missing or extra permanent teeth? ◯ Yes ◯ No

*HAS THE PATIENT EVER HAD ANY PAIN/TENDERNESS IN HIS/HER JAW JOINT (TMJ/TMD)? ◯ Yes ◯ No

*Does the patient brush his/her teeth daily? ◯ Yes ◯ No

Floss his/her teeth daily? ◯ Yes ◯ No

*Patient's Physician

Phone

Date of Last Visit

*Is the patient currently under the care of a physician? ◯ Yes ◯ No

*Please describe the patient's current physical health ◯ Good ◯ Fair ◯ Poor

Please list all drugs that the patient is currently taking

Please list all drugs that the patient is allergic to

## Has the patient ever had any of the following medical problems?

◯ Yes ◯ No *Abnormal Bleeding

◯ Yes ◯ No *Allergies to any Drugs

◯ Yes ◯ No *Allergy to Latex/Metals

◯ Yes ◯ No *Allergy to Plastic

◯ Yes ◯ No *Any Hospital Stays

◯ Yes ◯ No *Any Operations

◯ Yes ◯ No *Asthma

◯ Yes ◯ No *Cancer

◯ Yes ◯ No *Congenital Heart Defect

◯ Yes ◯ No *Convulsions/Epilepsy

◯ Yes ◯ No *Diabetes

◯ Yes ◯ No *Handicaps/Disabilities

◯ Yes ◯ No *Hearing Impairment

◯ Yes ◯ No *Heart Murmur

◯ Yes ◯ No *Hemophilia

◯ Yes ◯ No *Hepatitis

◯ Yes ◯ No *HIV+/AIDS

◯ Yes ◯ No *Kidney/Liver Problems

◯ Yes ◯ No *Rheumatic/Scarlet Fever

◯ Yes ◯ No *Tuberculosis (TB)

Please discuss any medical problems that the patient has had

## Does/Has the patient have/had any of the following habits?

| | | |
|---|---|---|
| Yes | No | *Clenching/Grinding Teeth |
| Yes | No | *Lip Sucking/Biting |
| Yes | No | *Mouth Breather |
| Yes | No | *Nail Biting |
| Yes | No | *Nursing Bottle Habits |
| Yes | No | *Speech Problems |
| Yes | No | *Thumb/Finger Sucking |
| Yes | No | *Tongue Thrust |

## Signatures

☐ *I understand that the information that 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 this office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary dental services I/my child may need.

☐ *This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use services of one or more credit reporting agencies.

☐ *If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

☐ *I understand that at the time of my office visit, my physical signature will be required to confirm the acknowledgements above.

Signature

Date