Patient Information

First Name _____ Last Name _____ Middle Name _____
Street Address _____ City _____ State _____ Zip _____
Home Phone _____ Birthdate _____ Marital Status _____ Sex _____
If patient is a minor, parent's / guardian's name _____
Name and Ages of Siblings _____
Email _____
Whom may we thank for referring you to our office? _____
Sports/Hobbies/Musical Instruments _____
School/Occupation _____ Current Grade _____ Nickname _____

Person Responsible For Account

First Name _____ Last Name _____ Middle Name _____
Street Address _____ City _____ State _____ Zip _____
Have you been at this address longer than 3 years? Previous Street Address _____
City _____ State _____ Zip _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Home Phone _____
Work Phone _____ Cell Phone _____ Email _____
Employer _____ Occupation _____ No. of years employed _____
Spouse's Name _____ Sex _____ Relationship to Patient _____
Social Security # _____ Birthdate _____ Work Phone _____ Cell Phone _____
Spouse's Employer _____ Occupation _____ No. of years employed _____

Dental Insurance Information

Insured's Name _____ Insured's Employer _____
Insured's Birthdate _____ Social Security # _____ Insurance Company _____
Group No. _____ Phone _____ Subscriber/Employee ID # _____
Insurance Co. Address _____
Do you have dual coverage? IF YES:
Insured's Name _____ Insured's Employer _____
Insured's Birthdate _____ Social Security # _____ Insurance Company _____
Group No. _____ Phone _____ Subscriber/Employee ID # _____
Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you _____
Relationship _____ Cell or 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?
Have there been any injuries to the face, mouth, teeth or chin?
How does the patient feel about wearing orthodontic appliances? _____
Has the patient been informed of any missing or extra permanent teeth?
Has the patient ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?
Does the patient brush his/her teeth daily? Floss his/her teeth daily?

Patient's Dentist _____ Phone _____ Date of Last Visit _____

Patient's Physician _____ Phone _____

Is the patient currently under the care of a physician? Has puberty begun? If yes, when? _____

Please describe the patient's current physical health:

Do you take or have you taken an osteoporosis medication?

Please list all drugs that the patient is currently taking _____

Please list all allergies (drugs, foods, other) _____

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

Abnormal Bleeding	ADD/ADHD	Allergy to Latex/Metals
Allergy to Plastic	Any Hospital Stays	Any Operations
Asthma	Cancer	Congenital Heart Defect
Convulsions/Epilepsy	Diabetes	Handicaps/Disabilities
Hearing Impairment	Heart Murmur	Hemophilia
Hepatitis	HIV+/AIDS	Kidney/Liver Problems
Psychological Counseling	Rheumatic/Scarlet Fever	Tuberculosis (TB)

Please discuss any medical problems that the patient has had

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

Chew/Smoke Tobacco	Clenching/Grinding Teeth	Lip Sucking/Biting
Mouth Breather	Nail Biting	Nursing Bottle Habits
Speech Problems	Thumb/Finger Sucking	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 _____