PATIENT INFORMATION

Today's Date:______________________________

Patient Name:____________________________________Nickname:___________________________________

Birthdate:____________________________Age:____________________Sex:______________________________

If a patient is a minor, parent/guardian's name:____

Mailing Address:____

Cell Phone:_____________________________________Cell Phone Carrier:_________________________________

Home Phone:__________________________Email address:____

Preferred method of communication: ________ Text ________E-Mail ________Phone

Patient's School/Employer:____________________________________Grade/Dept:_________________________

Hobbies/Sports/Musical Instruments:____

Patient's Dentist:___________________________________Referred by:_________________________________

RESPONSIBLE PARTY BILLING INFORMATION

Name:____Marital Status:___________________________

Mailing Address:____

Cell Phone:__________________Cell Phone Carrier:_________________Work Phone:_____________________

Relationship to Patient:______________________Birthdate:__________________SSN#:____________________

Employer:____Occupation:__________________________________

Spouse's Name:___________________________Cell Phone:______________Cell Phone Carrier:____________

Relationship to patient:______________________Birthdate:__________________SSN#:____________________

Employer:____Occupation:__________________________________

Patient Lives With: _____Parents _____Mother _____Father _____Other_______________________

INSURANCE INFORMATION

Insured's Name:____________________________________Insured's Date of Birth:________________________

Insured's SSN#:____________________________________Insured's Member ID#:_________________________

Insurance Company:_______________________________________Phone #:______________________________

Insured's Employer:____Group #:______________________________

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you:____

Address:____

Phone:__________________________________Relationship to patient:__________________________________

MEDICAL HISTORY OF PATIENT

Has there been any history of: (please circle and then describe below)

Asthma - Blood disorders - Breathing problems - Cancer - Diabetes - Epilepsy - HIV - Hepatitis
Heart Problems - Joint swelling - Kidney ailments - Liver ailments - Decrease in Bone Density
Artificial Joints/Valves - TB - ADD/ADHD - Sensation or Emotional Difficulties - Hearing Difficulties

If so, please describe:____

Do you currently take any medications? If yes, list:________________________________ YES NO

Do you have any allergies? (latex, metals, acrylic, plastics, medications)________________ YES NO

Have you had any major surgeries or hospitalizations?____________________________ YES NO

Do you bleed easily or is bleeding hard to stop?_________________________________ YES NO

Have you experienced any pain or clicking around the jaw joints?____________________ YES NO

Do you suffer from frequent headaches?_____________________________________ YES NO

Women, are you pregnant or nursing?_______________________________________ YES NO

DENTAL HISTORY OF PATIENT

Approximate date of last dental visit:_______________________Date of last x-rays:______________

Have there been cavities or abscessed teeth in the past?_____________________________ YES NO

Do your gums bleed easily when you brush or floss?________________________________ YES NO

Do you brush and floss your teeth daily?____________________________________ YES NO

Any serious problems associated with previous dental treatment?_____________________ YES NO

Have there been any injuries to the teeth? (Chips, falls, blows, etc)____________________ YES NO

Have any teeth been removed by extraction?____________________________________ YES NO

Was it suggested that the space be maintained?____________________________ YES NO

Was an appliance placed?____ YES NO

Do you breathe mainly through the mouth (are the lips usually parted)?__________________ YES NO

Have you ever had a habit or thumb/finger sucking, tongue thrust or lip biting?_____________ YES NO

Have you noticed any speech problems?_______________________________________ YES NO

Have you noticed any difficulty chewing food?___________________________________ YES NO

Are you aware of grinding or clenching your teeth?_______________________________ YES NO

Are you aware of any missing or extra teeth?____________________________________ YES NO

Are you dissatisfied with the appearance of your teeth or other facial structures?___________ YES NO

Are you sensitive regarding statements concerning your facial/teeth appearance?__________ YES NO

Has the patient seen an orthodontist before?____________________________________ YES NO

If so, please describe____

Has anyone in the family had orthodontic treatment?________________________________ YES NO

If so, please describe____

What concerns about your teeth and smile would you like orthodontics to address?__________________

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I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in the patient's medical and dental status. I authorize the orthodontic staff to take dental radiographs, study models or photos deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

Patient/Parent/Guardian Signature:____