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PATIENT INFORMATION

Today's Date:_____

Name:_____ Nickname:_____ ☐ Male ☐ Female

Social Security #:_____ Birthdate:_____ Age:_____

Address: _____

Home Phone:_____ Cell Phone:_____ Email:_____

Other family members seen by us:_____

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

Who will be financially responsible for your treatment?_____

SPOUSE'S INFORMATION

Name:_____ Social Security #:_____ Birthdate:_____

Address (if different from above):_____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____ Years Employed:_____ Occupation:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____

Relationship to patient:_____

Address:_____

Email:_____

Home #:_____

Cell #:_____

Work #:_____

Social Security#:_____

Birthdate:_____ Driver's Lic#:_____

Employer:_____

Employer's Address:_____

_____# years employed:_____

Employer's Phone #:_____

Occupation:_____

If less than 3 years with employer, please list previous employer:_____

ORTHODONTIC DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name:_____

Employer:_____

Insurance Company:_____

Ins. Co. Address:_____

Ins. Phone #:_____

Group #:_____

Member ID: _____

SECONDARY INSURANCE

Insured's Name:_____

Employer:_____

Insurance Company:_____

Ins. Co. Address:_____

Ins. Phone #:_____

Group #:_____

Member ID: _____

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

SIGNATURE:_____Date:_____

FOR OFFICE USE ONLY
Date:_____ Age:_____

FAMILY INFORMATION

Patient:_____Nickname:_____

Children? Name(s) and Age(s):_____

_____

MEDICAL HISTORY

Patient's Doctor:_____ Date Last Physical Exam:_____

General Health: ☐ Good ☐ Fair ☐ Poor

Do you have any history of major illness? Yes ☐ No ☐

If yes, please explain:_____

Do you need to be pre-medicated before dental treatment: Yes ☐ No ☐

List all drugs and/or medication being taken and reasons:_____

List any drug sensitivities:_____

Females: Are you pregnant? Yes ☐ No ☐ If yes, months into pregnancy: _____ Due Date: _____

Please check if you have or had any of the following diseases or medical problems:

- ☐ ADD
- ☐ Alcohol /Drug Abuse
- ☐ Allergies / Sinus Trouble
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Disorders
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Emotional / Mental Illness
- ☐ Endocrine Problems
- ☐ Epilepsy / Seizures
- ☐ Frequent Headaches
- ☐ Heart Murmur / Defects
- ☐ Hepatitis / Jaundice
- ☐ Hemophilia / Abnormal Bleeding
- ☐ HIV Positive / AIDS
- ☐ Hives / Skin Rash
- ☐ Lethargy
- ☐ Rheumatic Fever
- ☐ Sleep Apnea or Excessive Snoring
- ☐ Tonsils / Adenoids Removed
- ☐ Tuberculosis
- ☐ Ulcers

Other serious illness:_____

DENTAL HISTORY

Patient's Dentist:_____ Date Last Dental Exam:_____

Address:_____ Phone:_____

Please check if you have or had any of the following conditions:

- ☐ Bleeding Gums
- ☐ Canker Sores
- ☐ Chewing Difficulties
- ☐ Clicking or Popping Jaw
- ☐ Grinding of Teeth
- ☐ Herpes / Cold Sores
- ☐ Injuries to Face, Mouth or Teeth
- ☐ Missing or Extra Teeth
- ☐ Mouth Breathing, Awake or Asleep
- ☐ Sensitive Teeth
- ☐ Speech Problems
- ☐ Thumb / Finger Sucking
- ☐ Tongue Thrusting

HAS EITHER PARENT HAD:

- ☐ Orthodontic Treatment
- ☐ Similar Problem
- ☐ Teeth Removed

Has an orthodontist been consulted previously? ☐ Yes ☐ No If yes, doctor's name:_____

What is the main concern about your teeth? _____

Are you worried about orthodontic treatment? ☐ Yes ☐ No

Are you under any unusual stress at home or work? ☐ Yes ☐ No

EMERGENCY INFORMATION

Name:_____ Relationship to patient:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Patient Signature:_____ Date:_____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC & ADA.