

| | | | | | | | |
|--|--|-----------------|--|-----------|--|-------------------------|--|
| Patient's Name _____ | | _____ | | _____ | | _____ | |
| Last | | First | | (Common) | | Middle | |
| Address _____ | | | | _____ | | | |
| Street | | City | | State | | Zip | |
| Home Phone _____ | | Birthdate _____ | | Age _____ | | Social Security # _____ | |
| If patient is a minor, give patient's or guardian's name _____ | | | | | | | |
| Whom may we thank for referring you to our office? _____ | | | | | | | |
| Family Dentist _____ | | | | | | | |

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

| | | | | | | | |
|--|--|------------------|--|-------------------------------|--|--------|--|
| Name _____ | | _____ | | _____ | | _____ | |
| Last | | First | | (Common) | | Middle | |
| Residence _____ | | | | _____ | | | |
| Street | | City | | State | | Zip | |
| Mailing Address _____ | | | | _____ | | | |
| Street | | City | | State | | Zip | |
| How long at this address _____ | | Home Phone _____ | | Work Phone _____ | | | |
| Previous Address (if less than 3 yrs.) _____ | | | | | | | |
| Street | | City | | State | | Zip | |
| Social Security # _____ | | Birthdate _____ | | Relationship to Patient _____ | | | |
| Employer _____ | | Occupation _____ | | No. Years Employed _____ | | | |
| Spouse's Name _____ | | _____ | | _____ | | _____ | |
| Last | | First | | (Common) | | Middle | |
| Employer _____ | | Occupation _____ | | No. Years Employed _____ | | | |
| Social Security # _____ | | Birthdate _____ | | Work Phone _____ | | | |

ORTHODONTIC INSURANCE INFORMATION

| | | | | | |
|--------------------------------|--|--|--|---------------------------|--|
| Policy Holder's Name _____ | | _____ | | and Soc. Security # _____ | |
| Insurance Company _____ | | Group No. _____ | | Union Local No. _____ | |
| Insurance Co. Address _____ | | Insurance Co. Phone _____ | | | |
| Policy Holder's Employer _____ | | | | | |
| Do you have dual coverage? | | No <input type="checkbox"/> Yes <input type="checkbox"/> | | If yes: | |
| Policy Holder's Name _____ | | _____ | | and Soc. Security # _____ | |
| Insurance Company _____ | | Group No. _____ | | Union Local No. _____ | |
| Insurance Co. Address _____ | | Insurance Co. Phone _____ | | | |
| Policy Holder's Employer _____ | | | | | |

EMERGENCY INFORMATION

| | |
|--|--------------------|
| Name of nearest relative not living with you _____ | |
| Complete Address _____ | |
| Phone _____ | Relationship _____ |

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

ORTHODONTIC INFORMATION

Name the patient likes to be called _____ Age _____
What are the main concerns that you would like orthodontics to accomplish? _____

Has the patient ever been evaluated or had orthodontic treatment before? _____
Other family members in orthodontic treatment _____
List siblings with age: _____

DENTAL HISTORY

Family Dentist _____
How often do you visit your family dentist for cleanings? _____
How often do you brush your teeth? _____
Do your gums bleed when brushing your teeth? _____
Do you have discomfort in the teeth, face, or jaw joint? _____
Are you aware of your jaw joints making noise? _____
Have you had any trauma involving the face or teeth? _____
Have you been informed of any missing or extra permanent teeth? _____
Have either the adenoids or tonsils been removed? _____ Date _____

HABITS

Has the patient ever had any of the following problems?

| | | | | | | | | |
|---|---|----------------------------|---|---|-----------------------|-------|-------|------------------------|
| Y | N | Clenching / Grinding Teeth | Y | N | Nail Biting | Y | N | Thumb / Finger Sucking |
| Y | N | Lip Sucking / Biting | Y | N | Nursing Bottle Habits | Y | N | Tongue Thrust |
| Y | N | Mouth Breather | Y | N | Speech Problems | Other | _____ | |

MEDICAL HISTORY

Has the patient ever had any of the following medical problems? Y or N for each item.

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Heart Disease / problems | Y | N | High / Low blood pressure |
| Y | N | Rheumatic fever | Y | N | Asthma / Difficult breathing / Sinus problems |
| Y | N | Abnormal bleeding | Y | N | Fever blisters / Ulcers |
| Y | N | Heart murmur | Y | N | Venereal / Sexually transmitted disease |
| Y | N | Bone disease / Problems in healing broken bones | Y | N | Nervous / Emotional problems |
| Y | N | Arthritis / Rheumatism | Y | N | Cancer / Tumor / Radiation or Chemotherapy |
| Y | N | Hepatitis | Y | N | Severe or Frequent headaches |
| Y | N | Shingles | Y | N | Hemophilia / Abnormal bleeding / Anemia |
| Y | N | HIV+ / AIDS | Y | N | Kidney / Liver problems |
| Y | N | Diabetes / Tuberculosis (TB) | Y | N | Drug or Alcohol addiction |
| Y | N | Seizures / Epilepsy / Fainting spells | | | |

Teenagers: Has the patient reached puberty? Y N

Females: is there any possibility of pregnancy? Y N Has menstruation begun? (girls) Y N Age _____

Physician: _____ Phone# _____

Date of last visit: _____

Is this patient currently being treated by a physician? Y N Explain: _____

Are prescription / over-the-counter drugs being taken? Y N Please list: _____

The patients current physical health is: Good Fair Poor

Please describe any medical condition / Problem not listed above: _____

Are there any allergies to any of the following:

| | | | | | | | | | | | | |
|---|---|--------------------|---|---|--------------|---|---|---------|---|---|--------------------|--------------|
| Y | N | Penicillin | Y | N | Tetracycline | Y | N | Latex | Y | N | Erythromycin | Other: _____ |
| Y | N | Any metal/ plastic | Y | N | Aspirin | Y | N | Codeine | Y | N | Dental Anesthetics | _____ |

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 medical status.

Signature of parent / guardian / patient _____

Date _____