



Welcome to our office! In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. You can either print out this form or submit it online. Thank you for your cooperation!

Patient Information

Last Name _____ First name _____ Middle _____
I prefer to be called (Nickname) _____ Gender Male Female
Birth date (MM-DD-YYYY) _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell/Other Phone _____
Email _____ School _____ Grade _____
Patient siblings (Name and age) _____
Whom may we thank for referring you to our office? _____

Responsible Party Information

Responsible Party Last Name _____ First Name _____
Residential Address _____ City _____ State _____ Zip _____
Mailing Address _____ City _____ State _____ Zip _____
How long at this address _____ Home Ph. _____ Work Ph. _____ Cell Ph. _____
Previous Address (if less than 3 yrs) Street _____
City _____ State _____ Zip _____
Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____
Relationship to Patient _____ Employer _____
Occupation _____ Number of years employed with above employer _____

Spouse's Last Name _____ First Name _____
Address (if different) _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell/Other Phone _____
Birth date (MM-DD-YYYY) _____ Social Security # _____ Email _____
Relationship to Patient _____ Employer _____
Occupation _____ Number of years employed with above employer _____

Other adults we should know about

Last Name _____ First Name _____
Relationship to Patient _____ Phone _____ Email _____

Emergency Information

Who should we notify in case of emergency _____ Phone _____
Relationship to patient _____

Dental Insurance Information

Primary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? Yes No (If yes, please fill out the Secondary Policy Information below)

Secondary Policy Holder's Name _____ Social Security # _____

Insurance Company _____ Group # _____ Union Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Medical History

Physician _____ Phone _____ Date of Last Visit _____

Address _____

Has menstruation (period) begun? Yes No N/A If yes, when? _____

Please fill out the following fields and elaborate as necessary.

Yes No Is there a current medical problem? _____

Yes No Is the patient taking any pills, medications, or drugs? _____

Yes No Is the patient allergic to any medications or anesthetics? _____

Yes No Is the patient allergic to latex? _____

Yes No Is the patient allergic to anything else? _____

Yes No Has the patient had a serious illness? _____

Yes No Has the patient had any surgery or been hospitalized? _____

Yes No Has the patient ever had an injury to the head, face, or mouth? _____

Yes No Has patient's tonsils and/or adenoids been removed? _____

Yes No Does the patient snore? _____

Yes No Is patient sleepy during the day? _____

Please check any of the following conditions the patient has had or currently has

Abnormal/Prolonged Bleeding

Pneumonia

Psychiatric Care

Anemia/Blood Disease

Nervousness / Anxiety

Immune System Problems

Arthritis

Radiation / Chemotherapy

High Blood Pressure

Asthma

Rheumatic Fever

Sinus Trouble

Cancer

Tuberculosis

Fainting

Congenital Heart Defect

Tumor or other growths

Bone Disorders

Diabetes

Stomach Ulcers

Thyroid / Parathyroid Problems

Dizziness

Tonsillitis

Endocrine Problems

Epilepsy / Seizures

Herpes

Frequent Headaches

Heart Problems

HIV / AIDS

Hepatitis/Liver Problems

Heart Murmur

Kidney Problems

Gastrointestinal Disorders

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Dental History

Who is the patient's dentist? _____

When was the patient last seen by a dentist? _____

What was the reason for the visit? _____

Has any member of the family had orthodontic treatment? _____

What are your main concerns about your child's teeth and what would you like orthodontics to accomplish? _____

Has the patient:

Yes No Had trouble associated with dental treatment? _____

Yes No Had a previous orthodontic treatment or consultation?
With whom? _____ When _____

Yes No Had any teeth extracted? Why? _____

Yes No Ever injured or broken any teeth? When/what happened? _____

Yes No Ever injured the head or face? When/what happened? _____

Yes No Had any problems with eating, chewing, or swallowing? _____

Yes No Ever sucked thumb fingers bit nails? Until what age? _____

Yes No Dental or facial pain? _____

Yes No Jaw joints make a noise when opening/closing? _____

Yes No Jaw joints cause pain? _____

Yes No Teeth or jaws feel uncomfortable when you awake in the morning? _____

Yes No Clench or grind teeth? _____

Yes No Tension headaches? _____

Yes No Speech problems? _____

Yes No Normally breathe with lips parted? _____

Yes No Swellings or growths in mouth or face? _____

Yes No Had/has periodontal (gum) disease? _____

Yes No Any negative or resistant feelings about orthodontic treatment? _____

Yes No Dissatisfied with appearance of the teeth? _____

Yes No Specifically resistant to: Braces Headgear Retainers

Yes No Is there any other information we should know? _____

I understand that the information that I have provided 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 my medical, dental, or insurance status. 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 hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office. I understand that where appropriate, credit bureau reports may be obtained for the purpose of considering payment options.

Responsible Party Signature _____ Date _____

Spouse Signature (required if dual coverage) _____ Date _____