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Patient Information

Patient's Name ______________________________ ______________ Date __________
Last First Nickname

Male / Female Birthdate ________________ Age yrs. _____ Mos. ______ Home phone ______________

Residence ____
Street City State Zip

If patient is a minor, accompanying parent / guardian name ______________________________
Last First Relationship to patient

Whom may we thank for referring you to our office?

Responsible Party Information

Name ______________________________ ______________ Date __________
Last First Nickname

Address ____
Street City State Zip

E-mail Address (s)____

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 ______________________________ Relationship to Patient ______________
Last First

Employer __________________ Occupation __________________ No. Years Employed ____________

Social Security # __________________ Birthdate____________ Work Phone __________________

Orthodontic Insurance Information

Insured's Name ______________________________Insured's Social Security #____________
Last First

Insurance Company ________________ Group No. ________________ Ins Co. Phone______________

Insurance Company Address ____
Street City State Zip

Insured's Employer______________________________________ Insured's Birthdate ______________

Do you have dual coverage? Y / N?

Insured's Name ______________________________Insured's Social Security #____________
Last First

Insurance Company ________________ Group No. ________________ Ins Co. Phone______________

Insurance Company Address ____
Street City State Zip

Insured's Employer______________________________________ Insured's Birthdate ______________

Emergency Information

Name of nearest relative not living with you __________________________ Phone ________________

Address ____
Street City State Zip

To the best of my knowledge all information is correct.
I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ____

Medical Information

Patient's Physician: ____

Is patient in good health? ☐ Yes ☐ No ____

Does patient have any history of major illness? ______________________________________

Has patient been treated by a Physician for: (check where appropriate)

- ☐ **Asthma**
- ☐ **Liver Problems**
- ☐ **Thyroid Problems**
- ☐ **Hepatitis**
- ☐ **Presently Pregnant**
- ☐ **Tonsils / Adenoids Removed (age)** ____________
- ☐ **ADD / ADHD (list meds)**
- ☐ **Anemia**
- ☐ **Diabetes**
- ☐ **Kidney Problems**
- ☐ **Prolonged Bleeding**
- ☐ **Hypoglycemia**
- ☐ **Heart Problems**
- ☐ **Rheumatic Fever**
- ☐ **Epilepsy or Convulsions**
- ☐ **Other** ____________

Please discuss any medical problems: ____

____

List all drugs / things allergic to: ____

List all drugs currently being taken: ____

Dental Information

Name of general dentist: ______________________________ Office # ____________________

What are the main concerns that you would like the orthodontist to accomplish? ____________________

____

How do you feel about your smile? ***Love it*** ☺ |- -| ☹ ***I would like to improve it***

	No	Yes	If Yes, More Information
Has patient had a dental exam within 6 mos?			
Previous Orthodontic Treatment / Exams? When?			
Brushing / flossing difficulties?			
Injuries to mouth or teeth?			
Clicking or pain when opening jaws? Locking?			
Patient informed of missing / extra adult teeth?			
Difficulty chewing or eating?			
Teeth grinding or clenching?			
Has anyone else in the family worn braces?			
Has dentist removed any adult / baby teeth?			
Thumb sucking or finger habits?			
Speech problems / tongue thrust?			
Is patient a mouth breather / snorer?			
High intake of sweets?			
Any traumatic dental experiences?			

School Attending ____ Grade ____________

List Sports played____

Hobbies / Interests____

List any instruments played____

List brothers / sisters with age____

Friends that are patients____

Patient's attitude toward orthodontic treatment? ☐ Eager ☐ Complacent ☐ Not Enthusiastic

We welcome your comments or suggestions? ____

____

Updates (Date & Initial – for office use) ____

CONFIDENTIAL (for record and pretreatment evaluation) ______________________________________