



We would like to welcome you to our office. Please complete both sides of this form. All information is confidential. Thank you.

Patient Information

Date
Patient's First Name Last Name Middle Name
Address City State Zip Code
Home Phone Birth Date Age Sex Work Phone/Cell
If Patient Is A Minor, Give Parent or Guardian's Names
School Grade Age and Name of Other Siblings
Patient's Height Mother's Height Father's Height
Whom May We Thank For Referring You to Our Office?

Responsible Party

First Name Last Name MI Marital Status
Address City State Zip Code
Mailing Address
How Long At This Address Home Phone Work Phone/Cell
Previous Address (if less than 3 years)
Social Security # Birth Date Relationship to Patient
Employer Occupation No. Years Employed
Spouse's Name Last Name MI Work Phone
Social Security # Birth Date Relationship to Patient
Employer Occupation No. Years Employed

Dental Insurance Information

Subscriber's Full Name Soc. Sec. #/ID# Date of Birth
Insurance Company Group No. Local No.
Insurance Complete Address and Phone #
Do you have dual coverage? Yes Group
If yes, please fill below:
Subscriber's Full Name Soc. Sec. #
Insurance Co. Group No. Local No.
Insurance Co. Complete Address and Phone #
Insured's Employer Date of Birth

Emergency

Name Of Nearest Relative Not Living With You Relationship
City State and Zip Phone

I Understand That Where Appropriate, Credit Bureau Reports May Be Obtained.

Signature (Parent's Signature If Patient Is A Minor)

## Medical And Dental History

Patient's Dentist \_\_\_\_\_ Last Dental Visit \_\_\_\_\_

Do You Need a Referral To A Dentist?: \_\_\_\_\_

What Concerns Would You Like Orthodontics To Accomplish? \_\_\_\_\_

Indicate The Patient's Feelings Towards Orthodontic Treatment \_\_\_\_\_

Has An Orthodontist Been Previously Consulted? \_\_\_\_\_

Are Antibiotics Necessary For Teeth Cleanings? \_\_\_\_\_

Is There Any Dental Work That Needs To Be Completed Prior To Orthodontic Treatment? \_\_\_\_\_

Physician \_\_\_\_\_ Last Physical Exam \_\_\_\_\_

Is The Patient Under The Care Of A Physician At This Time? Please Explain \_\_\_\_\_

List Any Medications Being Taken At This Time \_\_\_\_\_

List Any Drugs/Things That The Patient Is Allergic To Or Has A Reaction To \_\_\_\_\_

Has The Patient Ever Had Any Of The Following Medical Problems? \_\_\_\_\_

Abnormal Bleeding	Yes	No	Aids/HIV	Yes	No	Diabetes	Yes	No
Plastic/Metal Allergy	Yes	No	Heart Problems	Yes	No	Asthma	Yes	No
Latex Allergy	Yes	No	Cancer Or Tumor	Yes	No	Hepatitis	Yes	No
Epilepsy/Convulsions	Yes	No	Fainting Or Dizzines	Yes	No	Anemia	Yes	No
Thyroid Problems	Yes	No	Pregnant Now	Yes	No	Tuberculosis	Yes	No
Kidney/Liver Problems	Yes	No	Hemophilia	Yes	No	Disabilities	Yes	No
Heart Murmur	Yes	No	High Blood Pressure	Yes	No	Venereal Disease	Yes	No
Finger/Thumb Sucking	Yes	No	Cavities Now	Yes	No	Mouth Breathing	Yes	No
Tooth/Jaw Trauma	Yes	No	Smoke/Chew Tobacco	Yes	No	Headaches	Yes	No
Lip/Tongue Biting	Yes	No	Missing Permanent Teeth	Yes	No	Tongue Thrust	Yes	No
Tonsils/Adenoid Problems	Yes	No	Clenching Or Grinding	Yes	No	Extra Teeth	Yes	No

Please Explain Any Medical Or Dental Problems That The Patient Has Had \_\_\_\_\_

Do You Have Any Disease, Medical Or Dental Condition That Is Not Mentioned Above? \_\_\_\_\_

Has the patient ever experienced TMJ symptoms? \_\_\_\_\_

Please explain: \_\_\_\_\_

Any Trauma to face or mouth \_\_\_\_\_

### Affirmation

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status.

\_\_\_\_\_  
Signature Patient/Parent/Guardian

\_\_\_\_\_  
Date

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Verbally reviewed the medical/dental information above with the patient/parent/guardian and patient named herein.

Signed: \_\_\_\_\_ Date \_\_\_\_\_