

*Creating beautiful smiles...Enhancing beautiful faces!*

### PATIENT INFORMATION

Welcome to our Office!

Date \_\_\_\_\_

Patients Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent or guardian's name \_\_\_\_\_

Patient: \_\_\_\_\_ Responsible Party: \_\_\_\_\_  
E-mail Address E-mail Address

### RESPONSIBLE PARTY INFORMATION

Name \_\_\_\_\_  
Last First Middle Marital Status

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 years) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ # Years Employed \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_

### INSURANCE INFORMATION

Insured Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes? No? If yes, please continue \_\_\_\_\_

Insured Name \_\_\_\_\_ DOB \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insured Employer \_\_\_\_\_

### EMERGENCY INFORMATION

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

### CREDIT REPORT AUTHORIZATION

I understand that a credit bureau report may be obtained if an orthodontic financial plan is requested.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT MEDICAL HISTORY

Patient's Name \_\_\_\_\_ School Name \_\_\_\_\_

Name and ages of children and siblings \_\_\_\_\_

### CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sinus Problems     |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> HIV Positive (AIDS) | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Drug Addiction               | <input type="checkbox"/> Nervous Disorders   | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Endocrine Problems           |  |   |

- Does the patient gag easily?  Yes  No
- Does the patient wear contact lenses?  Yes  No
- Does the patient have frequent ear infections?  Yes  No
- Have tonsils and/or adenoids been removed?  Yes  No At what age? \_\_\_\_\_
- Women: Are you pregnant?  Yes  No
- Are medications now being taken?  Yes  No Please list type and reason: \_\_\_\_\_
- Does the patient have any allergies to:  Yes  No If yes, please list: \_\_\_\_\_  
foods, medications, environmental (i.e. hay fever) \_\_\_\_\_

## PATIENT DENTAL HISTORY

Dentist's Name \_\_\_\_\_ Approximate date of last dental exam \_\_\_\_\_

- Have there ever been any injuries to the face, mouth, or teeth?  Yes  No If yes, please explain: \_\_\_\_\_
- Has the patient ever sucked their fingers or thumb?  Yes  No Until what age? \_\_\_\_\_
- Does patient have any speech problems?  Yes  No
- Is patient a mouth breather while asleep?  Yes  No
- Is patient a mouth breather while awake?  Yes  No
- Have you been informed on any extra/missing permanent teeth?  Yes  No
- Has patient ever had a previous orthodontic exam?  Yes  No
- Have any family members had orthodontic treatment?  Yes  No
- Is there pain in the jaw joint? If Yes.....  Right  Left When did this begin? \_\_\_\_\_
- Is there any popping or cracking of the jaw joint? If Yes.....  Right  Left When did this begin? \_\_\_\_\_
- Does patient clench or grind teeth? If Yes.....  Night  Day When did this begin? \_\_\_\_\_
- Does patient have headaches?  Yes  No
- Frequency: \_\_\_\_\_ Location: \_\_\_\_\_

What is the chief concern that brought you to our office? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_