

**PATIENT INFORMATION**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
*Last First Middle*

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

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

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

Patient \_\_\_\_\_ Responsible Party \_\_\_\_\_  
*Email Address Email 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 \_\_\_\_\_ No. Years Employed \_\_\_\_\_

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

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

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

**INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's Soc. Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local No. \_\_\_\_\_

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

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

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ Insured's Soc. Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local No. \_\_\_\_\_

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

Insured's Employer \_\_\_\_\_

**EMERGENCY INFORMATION**

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

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

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

Signature (Parent's signature, if minor) \_\_\_\_\_ Date \_\_\_\_\_

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

**MEDICAL HISTORY**

Do you have a personal physician?  No  Yes  
 Physician's name: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
 Your current physical health is:  Good  Fair  Poor  
 Are you currently under the care of a physician:  No  Yes  
 Please explain: \_\_\_\_\_  
 Are you taking any prescription/over-the-counter drugs:  No  Yes  
 Please list each one: \_\_\_\_\_

**Have you ever had any of the following diseases or medical problems?**

- |                                |                                 |
|--------------------------------|---------------------------------|
| Y N Heart Attack/Stroke        | Y N Psychiatric Problems        |
| Y N Cancer/Chemotherapy        | Y N Heart Murmur                |
| Y N Epilepsy/Seizures/Fainting | Y N Diabetes/Tuberculosis       |
| Y N Rheumatic Fever            | Y N Drug/Alcohol Abuse          |
| Y N HIV+/AIDS                  | Y N Venereal Disease            |
| Y N Heart Surgery/Pacemaker    | Y N Shingles                    |
| Y N Hemophilia/Abnormal Ding   | Y N Ulcers/Colitis              |
| Y N Mitral Valve Problems      | Y N Congenital Heart Defect     |
| Y N Kidney Problems            | Y N Anemia/Radiation Treatment  |
| Y N Artificial Valves          | Y N Difficulty Breathing        |
| Y N Sinus Problems             | Y N Hospitalized For Any Reason |
| Y N High/Low Blood Pressure    | Y N Hepatitis                   |
| Y N Fever Blisters             | Y N Blood Transfusion           |
| Y N Severe/Frequent Headaches  | Y N Emphysema/Glaucoma          |

Please list any medical conditions you have ever had: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DENTAL HISTORY**

What are the main concerns you would like orthodontics to accomplish?

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Have you ever been evaluated for orthodontic treatment?  No  Yes  
 Have you ever had a serious/difficult problem associated with any previous dental work?  No  Yes  
 Do you now or have you ever experienced pain or discomfort in your jaw joint?  No  Yes  
 Your current dental health is:  
 Do you like your smile:  No  Yes  
 Do your gums ever bleed:  No  Yes  
 Have you ever had an injury to your (circle): Mouth Teeth Chin  
 Do you have any speech problems:  No  Yes  
 Do you generally breathe through your mouth AWAKE:  No  Yes  
 Do you generally breathe through your mouth ASLEEP:  No  Yes  
 Do you have any missing or extra permanent teeth:  No  Yes

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

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

**Thank you for filling out this form completely.**

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services.

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