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Date _____

PATIENT INFORMATION

Patient's Full Name _____ **Date of Birth** _____ **Age** _____ **Sex** _____
Address _____ **City/State** _____ **Zip Code** _____
Home Phone _____ **School** _____
Email _____
Names of Brothers and Sisters _____
Hobbies and Interests _____ **Sporting Activities** _____
Names of friends or relatives who were former patients _____
If patient is a minor, give parent's name or guardian's name _____
Whom may we thank for referring you to our office? _____

Patient's Dentist _____ **Patient's Physician** _____

RESPONSIBLE PARTY INFORMATION (for patients under the age of 18)

Father _____
Mailing Address _____
Home Phone _____ **Work Phone** _____ **Social Security #** _____ **Date of Birth** _____
Employer _____ **Occupation** _____

Please Circle Parents are: Married Separated Divorced Widowed Never Married

Mother _____
Mailing Address _____
Home Phone _____ **Work Phone** _____ **Social Security #** _____ **Date of Birth** _____
Employer _____ **Occupation** _____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? YES NO If yes please complete the following:
Insured's Name _____ **Date of Birth** _____ **Insured's Social Security #** _____
Insurance Company _____ **Group #** _____ **Local #** _____
Insurance Company Address _____
Insurance Company Phone # _____ **Insured's Employer** _____

Do you have dual coverage? YES NO If yes, complete the following:
Insured's Name _____ **Date of Birth** _____ **Insured's Social Security #** _____
Insurance Company _____ **Group #** _____ **Local #** _____
Insurance Company Address _____
Insurance Company Phone # _____ **Insured's Employer** _____

CONTINUED ON BACK ----->



EMERGENCY INFORMATION

Name of emergency contact person _____

Relation _____ Phone # _____

DENTAL HISTORY

Does patient receive regular dental checkups? YES NO

Last dental exam _____ Last dental x-rays _____

Has patient received any previous orthodontic consultation or treatment? _____

How often does patient brush their teeth? _____ Is floss used? _____ How often? _____

Does the patient currently have, or has the patient ever had any of the following?

Y N Periodontal disease

Y N Gum surgery

Y N Root canals, crowns or bridges

Y N Any clicking, popping or pain of jaw, joints (TMJ)

Y N Any missing or extra teeth

Y N Trouble chewing

Y N Any past facial or mouth injuries What? _____

What are you or your Dentist most concerned about? (Purpose of visit) _____

ORAL HISTORY

The following are some habits commonly found which may influence tooth position. List info as pertains to patient:

Y N Thumb sucking / until age _____

Y N Finger sucking / until age _____

Y N Nail biting

Y N Mouth breather

Y N Grinding of Teeth

Other habits _____

Has patient ever had any speech therapy? _____

List any musical wind instruments played _____

HEALTH HISTORY

Has patient been under the care of a physician during the past two years? (other than routine checks) Y N

If yes, what for? _____

Is patient currently taking medications? _____

Is patient allergic to anything (drugs, food, pollen, etc.)? _____

Does the patient currently have, or has the patient ever had any of the following?

Y N Tonsils Removed

Y N Epilepsy / Seizures

Y N Nasal airway problems

Y N Adenoids removed

Y N Asthma

Y N Sinus problems

Y N Heart Problems

Y N Bleeding problems

Y N Speech problems

Y N Diabetes

Y N High Blood Pressure

Y N Arthritis

Y N Anemia

Y N Immune Disorders

Y N Tobacco usage

Y N Pneumonia

Y N Lung Problems

Y N Respiratory problems

Y N Hepatitis

Y N Tuberculosis

Does the patient have any special problems not listed above? _____