Patient Information

Patient's Name _____
Last First Name prefer to be called Middle Init

E-mail Address _____

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Sex ____ Social Security# _____

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

Whom may we thank for referring you to our office? _____ General Dentist _____

Family member in or out of orthodontic treatment _____

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 _____ Cell _____

Previous Address (if less than 3 yrs.) _____ How Long? _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Do you have insurance that covers braces?
Yes _____ No _____

If yes, please provide our office with your insurance card.

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I understand that when appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initial) _____ _____ _____ _____ _____

Please check yes if the **patient** has or has had any of the following:

MEDICAL HISTORY

Yes	No		Yes	No		Yes	No	
❑	❑	Anemia	❑	❑	Tonsilitis/Adenitis	❑	❑	Head/face injuries
❑	❑	Hepatitis	❑	❑	Tonsils removed	❑	❑	Dental injuries
❑	❑	Kidney problems	❑	❑	Adenoids removed	❑	❑	Thumb/finger sucking
❑	❑	Asthma	❑	❑	AIDS/HIV positive	❑	❑	Cheek/lip/nail biting
❑	❑	Rheumatic fever	❑	❑	Mouthbreathing	❑	❑	Difficult oral surgery
❑	❑	Heart disease	❑	❑	Speech/hearing problems	❑	❑	Clench/grind teeth
❑	❑	Heart murmur	❑	❑	Allergies	❑	❑	Click/pop of jaw joint
❑	❑	Stroke	❑	❑	High/Low blood pressure	❑	❑	Jaw pain
❑	❑	Tuberculosis	❑	❑	Drug sensitivity	❑	❑	Pain around ear
❑	❑	Diabetes	❑	❑	Neurological problems	❑	❑	Frequent headaches
❑	❑	Endocrine probs.	❑	❑	Radiation treatment	❑	❑	Bleeding gums
❑	❑	Bone disorders	❑	❑	Venereal disease	❑	❑	Sensitive teeth
❑	❑	Epilepsy	❑	❑	Pregnancy	❑	❑	Frequent cold sores
❑	❑	Psychiatric care	❑	❑	Ulcer or colitis	❑	❑	Periodontal treatment
❑	❑	Cleft lip/palate	❑	❑	Cancer/leukemia	❑	❑	Cigarette/pipe smoking
❑	❑	Arthritis						

DENTAL HISTORY

Describe any current medical treatment including drugs taken, even though not listed above:

_____

_____

Yes	No	
❑	❑	Has the patient ever been treated in an emergency room? Why? _____
❑	❑	Has the patient ever had any unfavorable reactions to medicine? Describe _____
❑	❑	Does the patient presently take any daily medication? What? _____
❑	❑	Is the patient currently under the care of a physician for a present condition? If yes, for what? _____ Physician's name: _____ Phone _____
❑	❑	Is the patient concerned about the appearance of his/her teeth?
❑	❑	Does the patient play a musical instrument?
❑	❑	Has the patient had previous orthodontic consultation and/or treatment?
❑	❑	Has any member of the family had orthodontic treatment?
❑	❑	Are you aware that some appointments will infringe on school and/or work time?
❑	❑	GIRLS: Has the patient started monthly period? If yes, at what age? _____
❑	❑	BOYS: Has the patient's voice changed? If yes, at what age? _____

Signature (Parent's signature if minor) _____

Updates (date & initial) _____