PATIENT INFORMATION

Patient's Name_____Date_____

Nickname_____ Social Security #_____

Address_____
Street City State Zip

Home Phone_____ Work Phone_____

Cell Phone_____ Email Address_____

Birthday_____/_____/_____ Age_____ Male ____ Female_____ Adopted_____

Employer_____ Phone Number_____

Other family members that have been treated here_____

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

IF PATIENT IS A MINOR

School_____ Grade_____

Hobbies_____

Patient lives with _____Both Parents _____Mother _____Father _____Other

RESPONSIBLE PARTY INFORMATION

Father's Name_____
(or Spouse's)

Address_____
Street City State Zip

Home Phone_____ Work Phone_____

Cell Phone_____ Social Security # _____/_____/_____ Birthday _____/_____/_____

Marital Status _____ Employer_____

Mother's Name_____

Address (if different)_____
Street City State Zip

Home Phone(if different)_____ Work Phone_____

Cell Phone_____ Social Security # _____/_____/_____ Birthday _____/_____/_____

Marital Status _____ Employer_____

DENTAL INSURANCE INFORMATION

Insured's Name_____

Insured's Social Security #_____/_____/_____ Insured's Date of Birth _____/_____/_____

Dental Insurance Company_____ Group #_____

Dental Insurance Company Address_____

Phone Number_____

Do you have dual coverage? _____No _____ Yes If Yes:

Insured's Name_____

Insured's Social Security #_____/_____/_____ Insured's Date of Birth_____/_____/_____

Dental Insurance Company_____ Group #_____

Dental Insurance Company Address_____

Phone Number_____

MEDICAL HISTORY

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

☐ Asthma ☐ Anemia ☐ Abnormal Bleeding ☐ Blood Disease ☐ Cancer ☐ Diabetes ☐ Earaches
☐ Emotional Problems ☐ Endocrine Problems ☐ Epilepsy ☐ Heart Problems ☐ Hepatitis ☐ Herpes ☐ HIV
☐ Leukemia ☐ Tonsillitis ☐ Woman: Are you pregnant ? ☐ Other_____

Do you have any drug allergies ? _____No _____Yes If yes, please describe _____

_____

Have you had rheumatic fever, congenital heart lesions, or damaged artificial heart valves ? _____ No _____Yes

If yes , please describe_____

Do you have a heart murmur ? _____No _____Yes Are you currently taking any medication ?_____

Do you take pre-medication when you see the dentist? If so, what kind? _____

DENTAL INFORMATION

Patient's General Dentist_____

Please check if the patient has had any of the following :

☐ Clenching /Grinding Teeth ☐ Thumb or Finger Sucking ☐ Tongue Thrust / Speech Problems
☐ Periodontal Problems ☐ Jaw or Joint Problems ☐ Missing or Extra Teeth

Has the patient ever had any orthodontic treatment or worn an appliance ?_____

Please describe briefly any problems the patient has that you want corrected by orthodontic treatment and/or the reason for this appointment. _____

_____

_____