Patient Information

A B C

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Date Of Birth _____ Home Phone_____ Cell Phone_____

Email Address _____

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

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

Responsible Party Information

Name _____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home/Cell Phone _____ Work Phone _____

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

Social Security #_____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ Number of Years Employed _____

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

Employer _____ Occupation _____ Number of Years Employed _____

Social Security #_____ Date of Birth _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group #_____ Local # _____

Insurance Company Address_____

Do you have dual coverage? Yes ☐ No ☐ If yes: Insurance Company Phone #_____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group #_____ Local#_____

Insurance Company Address_____

Insured's Employer_____

Emergency Information

Name of the nearest relative not living with you _____

Complete Address_____

Phone #_____ Relationship: _____

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

Signature (Parent's signature if minor) _____

Updates (Date & Initial) _____

Have you ever been seen by an orthodontist? _____

Have you ever had braces? _____

General Dentist: _____ Last Checkup & Cleaning: _____

In your opinion what is wrong with your teeth? _____

Patient's concerns: _____

Patient's attitude: _____

Do you mind having braces? _____

Have you had any injuries to your jaw? _____ Teeth? _____When?_____

Father's Height? _____ Mother's Height? _____ Patient's Height? _____

Resembles? _____ Growth the past year? _____ Adopted? _____

Do you have siblings? _____

Do you have children? _____

Present Health: Excellent ⬭ Good ⬭ Fair ⬭ Poor ⬭

Medical History- Do you have or have you ever had any of the following:

	Yes	No		Yes	No
Allergic to Latex/Metals	___	___	HIV/AIDS	___	___
Are you pregnant?	___	___	Hepatitis	___	___
Abnormal Heart condition	___	___	Anemia	___	___
If so, is a premed required?	___	___	Asthma	___	___
Abnormal blood pressure	___	___	Diabetes	___	___
Have you ever fainted?	___	___	Epilepsy	___	___
Difficulty Chewing/Swallowing	___	___	Rheumatic Fever	___	___
Tendency to colds/sore throats	___	___	TMJ Problems	___	___
Ear infections	___	___	Nail Biting	___	___
Injuries to teeth/face	___	___	Mouth Breathing	___	___
Allergies to Penicillin	___	___	Speech Problems	___	___
Local anesthetic	___	___	Thumb/Finger Habits	___	___
Medications/Drugs	___	___	Tongue Thrusting	___	___

Are you allergic to any medications or drugs? Please list here _____

Are you taking any medication? If so, for what? _____

Have you ever been hospitalized? _____ if yes, please explain when/why _____

Name of your Physician_____ Address _____

Do you anticipate a move or transfer in the near future? _____