PATIENT INFORMATION

Patient's Last Name_____First Name_____Gender_____

Birthdate_____Prefers to be called_____Home Phone #_____Cell#_____

Patient's Address_____City/State/Zip_____

Referred by_____Patient's Dentist_____

Attends School At_____City_____Grade_____

Names and ages of brothers and/or sisters_____

Other family members treated here_____

Custodial Parent's or Guardian's Name_____Home Phone #_____

Relationship to Patient _____Married_____Divorced_____Separated_____

Address_____City/State/Zip_____

Employer_____Occupation_____No. years___

Work Phone#_____Cell Phone#_____

Email address_____

Spouse's Name_____Employer_____

Occupation_____No. years_____Work Phone#_____

Cell phone#_____Email address _____

Who is financially responsible for this account?_____Date of Birth_____

Social Security#_____Drivers license # and state_____

Address and Phone# if not listed above_____

Insurance coverage for Orthodontic Treatment? Yes _____ No_____

INSURANCE (This office will not file your insurance unless we have a copy of your card and all insurance information on this form is filled out.

Name of Primary Insurance Co._____

Address_____City/State/Zip_____

Named of Insured_____Insurance ID No._____

Date of Birth_____Group #_____

Name of Secondary Insurance Co._____ Address_____

City/State/Zip_____ Name of Insured_____

Insurance ID No._____Date of Birth_____Group #_____

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MEDICAL HISTORY

Check if patient has or has had:

_____Joint swelling____Tuberculosis____Anemia
_____Bone disorders_____Epilepsy
_____Asthma_____Fainting spells
_____Heart trouble_____Rheumatic fever
____Birth defects or hereditary problems
_____Rheumatoid or arthritic conditions
_____Problems of the immune system
_____Unusual bleeding_____Thyroid problems
_____Diabetes_____Hepatitis_____HIV/AIDS
_____Tonsillectomy_____Adenoidectomy
_____Kidney Problem_____Endocrine disorder
_____Contact Lens_____Pregnancy
_____Emotional problem_____ADD/ADHD
_____History of eating disorder
_____Speech difficulties

Allergies or reactions to any of the following:

_____Ibuprofen (Motrin, Advil)
_____Tylenol
_____Other medications (list)_____
_____ Seasonal Allergies
_____Latex

Please list all medications the patient is currently taking:

_____
_____
_____

Does the patient need pre-medication before a medical/dental procedure?_____

DENTAL HISTORY

Check if the patient has or has had:

_____Injuries to the face, mouth, or teeth (circle)
_____Finger, thumb, or lip sucking habits (circle)
_____Mouth breathing when asleep or awake
_____Missing permanent teeth
_____Extra permanent teeth
_____Periodontal (gum) treatment
_____Teeth removed by extraction
_____Tongue thrusting habit
_____Pain or clicking upon jaw opening
_____Previous consultation with an orthodontist
_____Major orthodontic concern. Please list:
_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signed_____Date_____