

Welcome!

Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you (and/or) your child.

PATIENT INFORMATION

Name _____ Male / Female
Last Name First Name Initial
Address _____
City _____ State _____ Zip _____ Email _____
Home Ph# _____ Cell Ph# _____ Work Ph# _____
Birthdate ____/____/____ Age _____ Marital Status (if applies) Single Married Divorced
School attending (child) _____ Hobbies/Interests _____
Whom may we than for referring you? _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birthdate ____/____/____ Soc. Sec. # _____
Address (if different from above) _____
Home Ph# _____ Cell Ph # _____ Email _____
Employer _____ Occupation _____
Business Address _____ Business Ph# _____
Insurance Company _____ Phone # _____
Subscriber ID# _____ Group/Policy # _____

SECONDARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relation to Patient _____ Birthdate ____/____/____ Soc. Sec. # _____
Address (if different from above) _____
Home Ph# _____ Cell Ph # _____ Email _____
Employer _____ Occupation _____
Business Address _____ Business Ph# _____
Insurance Company _____ Phone # _____
Subscriber ID# _____ Group/Policy # _____

Please complete both sides

DENTAL HISTORY

Dentist _____ Phone # _____

Date of Last Dental Exam _____ Does your Dentist have any concerns? _____

Circle (Yes / No) if you / your child have had problems with any of the following:

Bad Breath	Yes / No	Bleeding gums	Yes / No	Clicking, popping, locking of jaw	Yes / No
Sensitivity to cold	Yes / No	Sensitivity to hot	Yes / No	Food collecting between teeth	Yes / No
Sensitivity to sweets	Yes / No	Periodontal treatment	Yes / No	Grinding/clenching teeth	Yes / No
Sores in mouth	Yes / No	Loose/Broken teeth	Yes / No	Thumb/finger sucking	Yes / No
Mouth breathing	Yes / No	Snoring	Yes / No	Nail biting	Yes / No

Any injuries to mouth or chin injury Yes / No If yes please explain _____

Have you / your child ever been evaluated for orthodontic treatment? Yes / No Orthodontist _____

MEDICAL HISTORY

Physician's Name _____ Phone # _____

Date of last visit _____ Any recent illnesses(or)surgeries Yes / No If yes describe _____

Are you / your child currently under physician care Yes / No If yes, describe _____

Have you / your child ever had a blood transfusion Yes / No If yes, when _____

Do you / your child still have: Tonsils Yes / No Adenoids Yes / No

Women: Are you pregnant? Yes / No Taking birth control pills Yes / No

Circle (Yes/ No) whether you / your child have (or) has any of the following:

AIDS/HIV+	Yes / No	Cough,persistant	Yes / No	High Blood pressure	Yes / No	Shingles	Yes / No
Anaphylaxis	Yes / No	Diabetes	Yes / No	Epilepsy	Yes / No	Anemia	Yes / No
Asthma	Yes / No	Fainting	Yes / No	Hemophillia	Yes / No	Cancer	Yes / No
Hepatitis	Yes / No	Heart Murmur	Yes / No	Jaw Pain	Yes / No	Atopic	Yes / No
Headaches	Yes / No	Kidney Disease	Yes / No	Glaucoma	Yes / No	Ulcers	Yes / No
Cold Sores	Yes / No	Tuberculosis	Yes / No	Mitral Valve Prolapse	Yes / No	Stroke	Yes / No
Heart Attack	Yes / No	Rheum . Fever	Yes / No	Liver Disease	Yes / No	Other	Yes / No
Sinus Prob.	Yes / No	Drug/Alcohol Abuse	Yes / No	Congenital Heart Def.	Yes / No		
Tobacco Use	Yes / No	Food Allergies	Yes / No	List:	_____		

Is patient currently taking any medications? If Yes, List all: _____

Does Patient have any drug allergies? If Yes, List all: _____

Allergic to LATEX YES / NO

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my / my child's medical status. I also authorize the orthodontic staff to perform the necessary orthodontic services I / my child may need.

Signature _____

Date _____