Patient ID#_____

Confidential Patient Information

Patient's Name _____

(LAST) (FIRST) (M.I.)

Nickname _____ Date of Birth _____ Date of Appointment_____

Phone: Home _____ Work _____ Cell _____

E – Mail: _____

Residence _____

(STREET) (CITY) (STATE) (ZIP)

Dentist_____ Referred by _____

Confidential Responsible Party Information

____DUAL INSURANCE

Father___ Husband___ Self___ Name _____

(LAST) (FIRST) (M.I.)

Date of Birth _____ Social Security #_____

Phone#: Home _____ Work _____ Cell _____

E – Mail address: _____

Address _____

(STREET) (CITY) (STATE) (ZIP)

Employer_____ Occupation _____

No. of Years Employed_____ Relationship to Patient_____

Dental Insurance Co._____ Group# _____ ID#_____

Dental Insurance Co. Address_____

Mother___ Wife___ Self___ Name_____

(LAST) (FIRST) (M.I.)

Date of Birth _____ Social Security #_____

Phone#: Home _____ Work _____ Cell _____

E – Mail address: _____

Address _____

(STREET) (CITY) (STATE) (ZIP)

Employer_____ Occupation _____

No. of Years Employed_____ Relationship to Patient_____

Dental Insurance Co._____ Group# _____ ID#_____

Dental Insurance Co. Address_____

Single _____ Married _____ Widowed_____ Separated_____ Divorced_____

Please List Patient's Siblings: _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

(OVER)

MEDICAL HISTORY

Patient's physician _____ Address _____

Date of last physical exam: _____ Height _____ Weight _____

Do you feel as though you are in good health? Yes_____ No _____

If no please explain: _____

Do you have any history of major illness? _____

Please check any of the following for which you have been treated:

Diabetes	____	Asthma	____	Allergies	____	Migraines	____
Heart Trouble	____	Epilepsy	____	Hepatitis	____	Rheumatic Fever	____
Depression	____	Anemia	____	Seizures	____	bleeding disorders	____
HIV/AIDS	____	Dizziness/Fainting	____	Hip/Joint replacement	____	ADD or ADHD	____

Do you have a tendency to: Gag ____ Faint ____ Colds ____ Sore throats ____ Cold sores ____ Canker sores ____

Have your tonsils and adenoids been removed? Yes ____ No ____ What age? _____

Please list any drugs or medications you are taking (please include herbal medications):

_____

Please list any allergies or drug sensitivity:

_____

Women: Are you pregnant at the present time? Yes ____ No _____

DENTAL HISTORY

Patient's Dentist _____ **Date of Last Check up / Cleaning** _____

How often do you brush your teeth? morning _____ after lunch _____ after dinner _____ before retiring _____

Have you ever been put on a tooth brushing program or have a history of periodontal problems? If yes please explain:

_____

Have any teeth been injured due to accidents or falls? Yes____ No_____

Have you had any severe head of face injuries? Yes____ No_____ If 'yes' at what age? _____

Please give a brief detail of your injuries: _____

Have you experienced any sensitivity or discomfort from your: gums _____ teeth _____ bite _____

Please explain _____

Do you clench or grind your teeth? Yes ____ No____ Did you ever suck your thumb or fingers? Yes ____ No ____

Do you have any speech problems? Yes ____ No ____ Are you a mouth breather? Yes ____ No ____

Have your wisdom teeth been removed? Yes ____ No ____

Have you had previous Orthodontic work? Yes ____ No ____ If so what age (approx)? _____ By whom? _____

Patient's chief Orthodontic concern? _____

Questions For Patients 16 Years & Younger

Has the patient reached puberty? Yes_____ No_____ Approximate increase in height in the last 6 months _____ inches.

Has the patient had any primary (baby) or permanent teeth removed? Yes _____ No_____

Does the patient appear to have early _____ normal _____ or late _____ eruption of permanent teeth?

What school does the patient attend? _____

What subjects does the patient like best? _____

What are the patient's favorite sports, hobbies, or pastimes? _____

Does the patient play a musical instrument? Yes _____ No _____ What Kind? _____

(OVER)