

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. _____

