Patient Information

Date _____

Patient's Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell phone _____ Birthdate _____ Social Security # _____

Responsible Party Information

Name _____ Marital Status _____

Residence _____

Mailing Address _____

Previous Address (if less than 3 years) _____

How long at this address _____ Home phone _____ Work phone _____ Cell _____

Email Address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____ Cell _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. address _____ Phone # _____

Do you have dental coverage? Yes ☐ No ☐ Do you have orthodontic coverage Yes ☐ No ☐

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone # _____

Privacy Information

With whom may we discuss the treatment plan and /or the financial information other than yourself?

Name	Relationship to patient
_____	_____
_____	_____
_____	_____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

CC: _____

HEALTH HISTORY

Main reason for visit today _____

Dentist's Name _____ Phone _____ Last visit _____

Physician's Name _____ Date of last medical visit _____

Birthdate _____ Age _____ Sex _____

Have you had an orthodontic consultation before? Yes No With whom? _____

Has anyone in your family had braces? Yes No Who: _____

Emergency Information

Name of nearest relative not living with you _____ Relationship _____

Current Address _____

Phone _____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLOWING:

	Yes	No		Yes	No
Teeth sensitive to cold, heat, sweets or pressure	___	___	Disclosing tablets or solution	___	___
Bleeding gums. How long _____	___	___	Excessive bad breath	___	___
Cigarettes, pipe or cigar smoking	___	___	Food impaction	___	___
Texture of toothbrush _____	___	___	Dental floss	___	___
Clenching or grinding	___	___	Mouth breathing	___	___
Unfavorable dental experience	___	___	Periodontal treatment	___	___
Complications from extractions	___	___	Orthodontic treatment	___	___
Swelling or lumps in mouth	___	___	Water pik	___	___
TMJ	___	___	Fluoride supplements	___	___
Unusual sounds in ear while eating	___	___	Fingernail biting, thumb sucking, finger sucking	___	___
			Canker sores, mouth ulcers or herpes virus	___	___

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLOWING:

	Yes	No		Yes	No		Yes	No
Allergies to drugs	___	___	Diabetes	___	___	Rheumatic fever	___	___
Allergies to anesthetics	___	___	Hepatitis	___	___	History of fainting	___	___
Any heart ailment or murmur	___	___	Malignancies	___	___	Sinus problem	___	___
is pre-med necessary	___	___	Tumors or growths	___	___	Tuberculosis	___	___
High blood pressure	___	___	Psychiatric care/ emotional problems	___	___	AIDS	___	___
Neurological problems	___	___	Respiratory disease	___	___	HIV or AIDS related virus	___	___
Excessive bleeding from cut or extraction	___	___	Seizure	___	___	ADD	___	___
Asthma	___	___	Pregnant now	___	___	ADHD	___	___
Hay fever or allergies in general	___	___	Wounds that healed slowly	___	___	Any condition that requires pre-medication	___	___
						What: _____		

What medication are you now taking? _____

Is there any other information about your health we should know? _____

_____

Signature (Parent's signature if minor) _____

FOR OFFICE USE ONLY

Diagnosis: Date:_____ Left CL _____; Right CL _____; OB _____%; OJ _____ mm;

_____

_____

_____

Fee:_____ TX Time: _____

Notes: _____

_____

_____