Patient Information

Section 1

Today's Date: _____

Patient's Name: _____
Last First Middle

E-mail Address: _____ SS#: _____

Birthdate: ____/____/____ Age: _____ Gender: _____

Address: _____
Street City State Zip

Phone Numbers: Home _____ Mobile _____

Primary Dentist: _____ Phone Number: _____ Date of Last Visit: _____

Section 2 (If you are under 18 years of age, please fill out the following)

Father's Name: _____ Birthdate: ____/____/____

Work #: _____ Mobile #: _____

SS #: ____-____-____ (for insurance billing purposes only)

Employer: _____ Marital Status: _____

E-mail Address: _____

Mother's Name: _____ Birthdate: ____/____/____

Work #: _____ Mobile #: _____

SS #: ____-____-____ (for insurance billing purposes only)

Employer: _____ Marital Status: _____

E-mail Address: _____

Person Responsible for Account: _____

Section 3

Dental Insurance Co. Name: _____

Orthodontic Coverage? Yes _____ No _____ Not sure _____

Insurance Co. Phone #: _____

Group #: _____ Policy #: _____

Policy Holder: Name _____ DOB _____ SS# _____

Section 4

What would you like your orthodontist to accomplish for you?

Have you had an orthodontic examination or treatment before? Yes _____ No _____

Have there been any injuries to your face, mouth, or teeth? Yes _____ No _____

Have you had any TMJ (jaw joint) symptoms? Yes _____ No _____

Has **puberty** begun? Yes _____ No _____ If yes, when? _____

(For women) Are you **pregnant**? Yes _____ No _____ If yes, how many weeks? _____

Please list all names and dosage of **medication** you are currently taking:

Section 5

Have you ever had any of the following medical problems?

Yes _____ No _____	Abnormal Bleeding	Yes _____ No _____	Allergies to any Drugs
Yes _____ No _____	Allergies to Latex / Metal	Yes _____ No _____	Any Hospital Stays
Yes _____ No _____	Any Operations	Yes _____ No _____	Artificial Joints / Valves
Yes _____ No _____	Asthma	Yes _____ No _____	Cancer
Yes _____ No _____	Congenital Heart Defect	Yes _____ No _____	Convulsions / Epilepsy
Yes _____ No _____	Diabetes	Yes _____ No _____	Disabilities
Yes _____ No _____	Heart Murmur	Yes _____ No _____	Hepatitis
Yes _____ No _____	HIV / AIDS	Yes _____ No _____	Kidney Disease
Yes _____ No _____	Rheumatic Fever	Yes _____ No _____	Tuberculosis

If yes to any of the above medical questions, please provide detailed information:

Section 6

Have you / has your child ever had any of the following habits?

Yes _____ No _____	Clenching / Grinding Teeth	Yes _____ No _____	Lip Sucking / Biting
Yes _____ No _____	Mouth Breathing	Yes _____ No _____	Nail Biting
Yes _____ No _____	Thumb / Finger Sucking	Yes _____ No _____	Tongue Thrust

Section 7 (Signature)

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

I authorize the dental staff to perform the necessary dental services I / my child may need.

Signature of Patient (if 18 and older) Date Signature of Parent or Guardian Date

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance or my parent's/guardian's insurance does not cover.

Signature of Patient (if 18 and older) Date Signature of Parent or Guardian Date

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