



Confidential Patient Information

A B C

Patient Name: Last First Middle
Address: Street City State Zip
Home Phone: Birthdate: Social Security #:
If patient is a minor, give parent's or guardian's name:
Whom may we thank for referring you to our office?:

Confidential Responsible Party Information

Name: Last First Middle Marital Status:
Residence: Street City State Zip
Mailing Address: Street City State Zip Email:
How long at this address: Previous Address: (if less than 3 years) Street City State Zip
Home Phone: Work Phone: Cell Phone:
Social Security #: Birthdate: Relationship to Patient:
Employer: Occupation: No. Years Employed:
Spouse's Name: Last First Middle Relationship to Patient:
Spouse Employer: Occupation: No. Years Employed:
Spouse Social Security #: Spouse Birthdate: Spouse Work Phone:

Insurance Information

*Complete or provide your insurance card to copy for your file.

Policy Holder's Name: Birthdate: SSN:
Insurance Co. Name: Group #: Union Local #:
Insurance Co. Address:
Insurance Co. Phone #:
Policy Holder's Employer:

Do you have dual coverage? No Yes If yes:
Policy Holder's Name: Birthdate: SSN:
Insurance Co. Name: Group #: Union Local #:
Insurance Co. Address:
Insurance Co. Phone:
Policy Holder's Employer:

Emergency Information

Name of nearest relative not living with you:
Complete Address:
Phone: Relationship:

I authorize this office to release any information necessary to submit and expedite insurance claims. I understand that I am responsible for all costs of orthodontic treatment, regardless of insurance coverage. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor): Date:

Updates (date & initial):

Please Continue on Back Side

Patient Medical History

1. Are you in good health?----- Yes No
2. Are you under the care of a physician? ----- Yes No
If yes, what condition: _____
3. Are you currently taking any medications? ----- Yes No
If yes, please list medications: _____
4. Do you have or have you had any of the following problems or diseases? (check box if yes)
 Heart Murmur - If yes, do you take medication prior to dental appointments? Yes No
 Heart Problem
 Hepatitis, Jaundice or Liver Disease
 Asthma or Hay Fever
 Diabetes
 Aids
 Other _____
5. Are you allergic to any drugs/medications (such as penicillin, codeine, aspirin) or have a latex allergy? - Yes No
If yes, what are you allergic to?: _____
6. Do you have any disease, condition or other problems not listed that you think we should know about? - Yes No
If yes, describe: _____

Patient Dental History

1. Do you have any pending dental work?----- Yes No
If yes, what? _____
2. When was your last dental check-up? _____
3. When was your last dental cleaning? _____
4. Have you ever had any abnormal bleeding associated with previous extractions, surgery or trauma? ---- Yes No
5. Do your gums bleed? ----- Yes No
6. Are you aware of grinding or clenching your teeth? ----- Yes No
7. Have there been any injuries to face, mouth or teeth? ----- Yes No
8. Do you have any speech problems? ----- Yes No
9. Have you ever been told of any missing or extra permanent teeth?----- Yes No
10. Do you experience pain or clicking in your jaw, ear or facial muscles upon opening your mouth?----- Yes No
Headaches?----- Yes No
Please describe: _____
11. Do you have or have you ever had any of the following habits?
 Thumb Sucking ----- Current Previously
 Nail Biting ----- Current Previously
 Tongue Sucking ----- Current Previously
 Mouth Breathing ----- Current Previously
 Tongue Thrusting ----- Current Previously
 Lip Biting ----- Current Previously
 Tongue Biting ----- Current Previously
 Abnormal Breathing --- Current Previously
12. Why are you seeking an orthodontic consultation? _____

It is your obligation to inform us of any health changes.