Date______________

Confidential Patient Information

A B C

Patient's Name________ Last ________ First ________ Middle ________ Nickname ________ M / F

Address________ Street ________ City ________ State ________ Zip

Home Phone________________ Cell Phone________________

Birthdate________________ Age________ School________________

Hobbies________________

If patient is a minor, give parent's or guardian's name________________

List brothers / sisters with age (add asterisk (*) after name if patient has been seen by us):________________

____

Whom may we thank for referring you to our office?________________

General Dentist: ________________

Confidential Responsible Party Information

Name________ Last ________ First ________ Middle ________ Marital Status________

Residence________ Street ________ City ________ State ________ Zip ☐ Own ☐ Rent

Mailing Address________ Street ________ City ________ State ________ Zip

How long at this address________ Home Phone________ Work Phone________

Previous Address (if less than 3 yrs.)________ Street ________ City ________ State ________ Zip

Social Security #________ Birthdate________ Relationship to Patient________

Employer________ Occupation________ No. Years Employed________

Spouse's Name________ Last ________ First ________ Middle ________ Relationship to Patient________

Employer________ Occupation________ No. Years Employed________

Social Security #________ Birthdate________ Work Phone________

Dental Insurance Information

Policy Holder's Name________ Birthdate________ Soc. Sec. #________

Insurance Company________ Group No.________ Union Local No.________

Insurance Co. Address________ Insurance Co. Phone________

Policy Holder's Employer________________

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

Policy Holder's Name________ Birthdate________ Soc. Sec. #________

Insurance Company________ Group No.________ Union Local No.________

Insurance Co. Address________ Insurance Co. Phone________

Policy Holder's Employer________________

Emergency Information

Name of nearest relative/friend not living with you________________

Complete Address________________

Phone________________ Relationship________________

I understand that the information that I have given is correct to the best of my knowledge. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees. While this office accepts insurance, I understand that I am responsible for payment of services rendered. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)________________ **Date**________

Updates (date & initial)________________

MEDICAL HISTORY

Has the patient ever had any of the following medical problems? Please circle Y or N for each item.

Y N Heart disease / problems
Y N Rheumatic fever
Y N Abnormal bleeding
Y N Heart murmur
Y N Bone disease / Problems in healing broken bones
Y N Arthritis / Rheumatism
Y N Hepatitis
Y N Shingles
Y N HIV / AIDS
Y N Diabetes / Tuberculosis (TB)
Y N Seizures / Epilepsy / Fainting spells
Y N High / Low blood pressure
Y N Asthma / Difficult breathing / Sinus problems
Y N Fever blisters / Ulcers
Y N Venereal / Sexually transmitted disease
Y N Nervous / Emotional problems
Y N Cancer / Tumor / Radiation or Chemotherapy
Y N Severe or frequent headaches
Y N Hemophilia / Abnormal bleeding / Anemia
Y N Kidney / Liver problems
Y N Drug or Alcohol addiction

Teenagers: Has the patient reached puberty? Y N Has menstruation begun? (girls) Y N Females: Is there any possibility of pregnancy? Y N

Is the patient currently being treated by a physician? Y N Explain: ____________________

Are prescription / over-the-counter drugs being taken? Y N Please list: ____________________

The patient's current physical health is: ☐ Good ☐ Fair ☐ Poor

Please describe any medical condition / problem not listed above: ____________________

Are there any allergies to any of the following:

Y N Penicillin Y N Tetracycline Y N Latex Y N Erythromycin Other: ____________________
Y N Any metal / plastic Y N Aspirin Y N Codeine Y N Dental Anesthetics ____________________

Describe other allergies: ____________________

Y N Are you aware of any missing / extra adult teeth?
Y N Any past or present discomfort / clicking in the jaw joint (TMJ)?
Y N Any past injuries to the: ☐ Mouth ☐ Teeth ☐ Chin
Y N Have the tonsils and / or adenoids been removed?
Y N Do the gums ever bleed when brushing?
Y N Has a physician or dentist advised taking antibiotics prior to dental procedures?
Please explain: ____________________

Do any of the following habits apply?

Y N Thumb / finger sucking
Y N Speech problems
Y N Constant mouth breathing
Y N Clenching / Grinding teeth
Y N Lip / cheek biting
Y N Tongue thrust swallow

ORTHODONTIC INFORMATION

What would you like orthodontic treatment to accomplish? ____________________

Y N Has the patient ever been evaluated by an orthodontist or had orthodontic treatment before / currently? ____________________

– For those already in treatment, transferring orthodontic care to our office –

Your previous orthodontic provider was an: ☐ Orthodontist ☐ Family Dentist ☐ Pediatric Dentist

Previous Dr.'s Name: ____________________

Address: ____________________ City: ____________ State: ________ Zip: ________

Phone #: ____________________

Are your orthodontic records: With you? Y N Currently being shipped to us? Y N Still at the above Dr.'s office? Y N

FOR OFFICE USE

Medical History reviewed: ______/______ ______/______ ______/______ ______/______
Init. Date Init. Date Init. Date Init. Date

Comments: ____________________