Patient Information

Date:_____

Patient's Name_____ Sex: M___ F___

Address _____ City_____ St._____ Zip_____

Home Phone_____ Birthdate _____ Social Security # _____

Parent/Guardian Name (only if Patient is a minor) _____

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

General Dentist's Name _____

Responsible Party Information

Name _____ Email _____

Residence_____ City_____ St._____ Zip_____

Mailing address _____ City_____ St._____ Zip_____

How long at this address?_____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years)_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Email _____

Employer_____ Occupation _____ No. Years Employed _____

Social Security #_____ Birthdate_____ Work Phone _____

Insurance Information

Primary Insured's Name_____ Birthdate_____ Social Security #_____

Insured's Employer _____

Insurance Company_____ Address _____ Phone # _____

Do you have dual coverage? Yes _____ No_____

Secondary Insured's Name_____ Birthdate_____ Social Security #_____

Insured's Employer_____

Insurance Company_____ Address_____ Phone # _____

Emergency Information

Emergency Contact's Name _____

Address _____ City_____ St._____ Zip_____

Phone _____ Relationship to patient _____

Medical Information on Back

Medical Information

Is the patient experiencing any health problems? Yes ☐ No ☐ Reason: _____

Any major or unusual illnesses? Yes ☐ No ☐ Explain: _____

Currently under physician's care? Yes ☐ No ☐ Reason: _____

Currently taking medication? Yes ☐ No ☐ List: _____

Allergies? Yes ☐ No ☐ List: _____

Drug Sensitivity? Yes ☐ No ☐ List: _____

Has the patient ever received blood transfusion? Yes ☐ No ☐ Reason: _____

Please circle if patient has or has had any of the following

Anemia	*Blood Disease*	*Prolonged Bleeding*	*Frequent Colds or Flu*
Rheumatic Fever	*Heart Murmur*	*Tuberculosis*	*Jaundice*
Epilepsy	*Herpes*	*Hepatitis*	*Been in risk group for Aids?*
HIV/Aids	*Diabetes*	*Asthma*	*Endocrine (hormone) Problems*
Tonsillitis	*Adenitis*	*Bone Disorders*	

Tonsils Removed? _____ Age: _____ Adenoids Removed? _____ Age: _____

Mouth breathing? While awake, while asleep, or both? _____

Has the patient had any severe head or face injuries? If yes, explain _____

History of thumb/finger sucking? If yes, at what age stopped? _____

Any previous orthodontic treatment? _____

Please circle if patient has a history

Clenching Teeth	*Grinding Teeth*	*Ringing in ears*	*Jaw Joint Popping*
Jaw Joint Clicking	*Jaw Joint Soreness*	*Headaches (frequent)*	*Muscular Soreness around Head/Neck*

Signature (parent/guardian if patient is a minor) _____

For office use only

Overbite _____ Crowding Upper _____ *Est. of time:* _____

Overjet _____ Crowding Lower _____ *Est. of Fee:* _____

Class Left _____ Dental Development Stage _____ Missing Teeth: _____

Class Right _____ Tentative Treatment Plan/Additional Comments _____