WELCOME TO OUR OFFICE!

(Please complete both sides)

Please help us get acquainted by filling in the following important information. Today's Date: _____

Patient's Name: Last _____ First _____ Nickname_____ Male / Female

Home Address_____ City_____ State_____ Zip_____

Date of Birth_____ Age_____ Yrs. _____Mos. Cell Phone Number _____

Home Phone _____ Patient e-mail _____

School _____ Grade _____

Hobbies/Interests _____SSN _____

Whom may we thank for this referral? _____

Patient's Dentist _____ Patient's Physician _____

Relatives treated here _____

FAMILY STATUS

Father or Spouse's Name _____ Date of Birth _____ SSN_____

(Please circle one)

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Email Address_____ Cell Phone _____

Mother or Spouse's Name _____ Date of Birth _____ SSN _____

(Please circle one)

Occupation _____ Employed By _____

Business Address _____ Business Phone _____

Email Address _____ Cell Phone _____

*__Preferred Contact__: *Phone Number _____ *E-mail _____

Patient Living With: MOTHER FATHER SELF OTHER _____

Person Financially Responsible for Account _____ Phone _____ Relationship _____

Address _____ Employer _____

DENTAL INSURANCE

Is patient covered by insurance for orthodontic treatment? YES NO

Policy Owner's Name_____ Policy Owner's Date of Birth_____

Policy Owner's SSN _____ Policy Owner's Employer _____

Insurance Company _____ Group # _____ ID # _____

Insurance Phone _____

I understand that where appropriate, credit reports may be obtained and my signature below authorizes such reports.

Signature_____ Date _____

EMERGENCY CONTACT
Person to be contacted if **patient or parent** cannot be reached?

Name _____ Relationship _____

Address _____ Phone _____

MEDICAL HISTORY

Check if patient has or has had any of the following:

YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Heart Disease / Murmur
☐	☐	Arthritis	☐	☐	Hepatitis / Liver Problems
☐	☐	Asthma	☐	☐	Herpes
☐	☐	Cancer	☐	☐	HIV+ OR AIDS
☐	☐	Blood Disorders	☐	☐	Nervous Disorders
☐	☐	Diabetes	☐	☐	History of Radiation / Chemotherapy
☐	☐	Epilepsy	☐	☐	Tuberculosis
☐	☐	Gastrointestinal Disorders			
☐	☐	Allergies (Seasonal, Latex, Nickel, etc.) _____			
☐	☐	Drug Allergies – Please list: _____			

Please list any drugs (medications) currently taking _____
Has the patient reached puberty? _____ When? _____
Any other medical information which may be helpful? _____

TMJ

YES	NO	
☐	☐	Has patient ever been treated for TMJ problems? _____
		Does patient have a history of:
☐	☐	- Pain or clicking in jaw joint
☐	☐	- Pain on chewing, yawning, opening wide
☐	☐	- Pain in ears / cheeks
☐	☐	- A bite that is “uncomfortable” or “unusual”
☐	☐	- A locked jaw
☐	☐	- Clenching / grinding

DENTAL HISTORY

YES	NO	
☐	☐	Are tonsils and adenoids still present?
☐	☐	Has patient ever had a severe head or facial injuries? _____
☐	☐	Has patient ever had injuries to the teeth? _____
☐	☐	Has patient ever sucked thumb or fingers? _____
☐	☐	Does the patient play any musical instrument that touches the lips? _____
☐	☐	Have you been informed of missing or extra teeth? _____
☐	☐	Does the patient have any speech problems? _____
☐	☐	Does patient have a problem with snoring? _____
☐	☐	Does the patient have a tongue thrust? _____
☐	☐	Previous orthodontic consultation or treatment _____

Date of last dental visit _____
Date of last dental cleaning _____
Date of last dental x-rays _____

What do you consider to be your main orthodontic problem? _____
Has your dentist pointed to an orthodontic problem? _____
What are your expectations of orthodontic treatment? _____
Is there any other information that might be helpful? _____

Signature _____ Date: _____

Relationship to patient _____