PATIENT INFORMATION

A B C

Date _____ Family Dentist _____ S B K NH B M

Patient's Name (Last, First, Middle) _____ M F _____ Age _____ Birthdate _____

Address (Street, City, State, Zip) _____

Home Phone _____ Cell Phone _____

School _____ Grade _____ Interests _____

Siblings (Name and Age) _____

In Case of emergency contact _____ Phone _____ Relationship _____

RESPONSIBLE PARTY INFORMATION

Custodial Parent's Name (Last, First, Middle) _____ Marital Status _____

Mailing Address (Street, City, State, Zip) _____ Email _____

How long at this Address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Number of Years Employed _____

Parent/Spouce's Name (Last, First, Middle) _____ Relationship to Patient _____

Address (Street, City, State, Zip) _____

Employer _____ Number Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

ORTHODONTIC INSURANCE INFORMATION

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Birthdate _____

Insurance Company Address _____

Do you have dual coverage? Yes No If Yes:

Insured/s Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Birthdate _____

Insurance Company Address _____

Chief Concern

Date of last dental visit?

Past dental facial trauma	Yes	No	Major accidents or surgery involving the face, neck, mouth or teeth?		Teeth broken, loosened or knocked out?		Missing teeth		
Jaw joint problems:	Yes	No	Locking	Pain	Noise	Discomfort Opening or closing	Frequent headaches	Clenching or grinding	
Oral problems	Yes	No	Canker/cold sores	Swollen/bleeding gums	Hepatitis	Habits Thumb/finger	Speech	Mouth Breathing Day ☐	Night ☐
Difficulty chewing or swallowing food?	Yes	No	Previous orthodontic treatment/consultation? Yes No			Orthodontist		Outcome	
Siblings had orthodontics?	Yes	No	Name/Stage of treatment:						
Parents had orthodontics?	Yes	No	Mother Father		Orthodontist		Results	Does patient's stature, teeth or mouth resemble: M F Neither	

Does anyone else in the family have a similar dentofacial condition:
Crowded, retruded or protruded teeth, protruding lower jaw, receding chin

MEDICAL HISTORY

Present Health: Excellent ☐ Good ☐ Fair ☐ Poor ☐ Physician:

Hospitalized in past 3 yrs?	Yes	No	Operations	Tonsils & Adenoids	Other
Chronic diseases?	Yes	No	(lungs, liver, kidney, heart, etc.)		
Presently under the care of a physician?	Yes	No	(diabetes, hepititis, high/low blood pressure, etc.)		
Presently under medication?	Yes	No	Medication:		Prescribed for:
Allergies:	Yes	No	Describe:		
Complications to previous treatment	Yes	No	(excessive bleeding, fainting, drug reaction?)		
Does the patient smoke?	Yes	No	(Or use any tobacco products) Yes No		

Any disease, condition or problem the orthodontist should know about?

Has the patient ever had any of the following conditions?

- ☐ AIDS/HIV +
- ☐ Asthma
- ☐ Epilepsy
- ☐ TB
- ☐ Venereal disease
- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Congenital Heart Defect
- ☐ Hemophilia
- ☐ Emotional Problems

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's/Guardian's signature if minor) _____

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