

**Patient Information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Birthday \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Previous Address (if less than 3 yrs) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthday \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Last First Middle

Social Security # \_\_\_\_\_ Birthday \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of Years Employed \_\_\_\_\_

**Insurance Information**

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ if Yes:

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Ins. Phone # \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_ Home Phone \_\_\_\_\_

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

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (Date & Initials) \_\_\_\_\_

NAME YOU WANT TO BE CALLED \_\_\_\_\_

NAMES OF OTHER FAMILY MEMBERS WE HAVE TREATED \_\_\_\_\_

**MEDICAL HISTORY**

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

YES		NO		YES		NO		YES		NO	
DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE OR THYROID.....	<input type="checkbox"/>	<input type="checkbox"/>			
PNEUMONIA.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>	PROLONGED BLEEDING.....	<input type="checkbox"/>	<input type="checkbox"/>			
HEART TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY.....	<input type="checkbox"/>	<input type="checkbox"/>	LIVER INVOLVEMENT.....	<input type="checkbox"/>	<input type="checkbox"/>			
RHEUMATIC FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA.....	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZINESS.....	<input type="checkbox"/>	<input type="checkbox"/>			
BONE DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY INVOLVEMENT.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUS DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>			

IS THE PATIENT IN GOOD HEALTH?.....  YES  NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS \_\_\_\_\_

DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS?.....

LIST ANY ALLERGIES OR DRUG SENSITIVITIES \_\_\_\_\_

DOES THE PATIENT WEAR CONTACT LENSES?.....

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? \_\_\_\_\_

GROWTH IN THE PAST 6 MONTHS \_\_\_\_\_ HAS PATIENT REACHED PUBERTY?.....

HEIGHT: PATIENT'S \_\_\_\_\_ MOTHER'S \_\_\_\_\_ FATHER'S \_\_\_\_\_

PATIENT'S PHYSICIAN: \_\_\_\_\_ LAST SEEN: \_\_\_\_\_

**DENTAL HISTORY**

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?.....  YES  NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE? \_\_\_\_\_

DOES THE PATIENT HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR THE EARS?...

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?.....

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS OR TREATMENT?.....

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH?.....

IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS?.....

DOES THE PATIENT HAVE ANY CONGENITAL ABNORMALITIES?.....

PATIENT'S DENTIST \_\_\_\_\_ LAST SEEN \_\_\_\_\_

LIST SPORTS AND INTERESTS \_\_\_\_\_