Patient Information

Date________________________

Patient's Name____

Address____
Street City State Zip

Home Phone_____________________ Birthday________________ Social Security #________________________

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 ____

Updates (Date & Initials) ____

Confidential (for record and pretreatment evaluation)

NAME YOU WANT TO BE CALLED____

NAMES OF OTHER FAMILY MEMBERS WE HAVE TREATED______________________________

MEDICAL HISTORY

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

	YES	NO		YES	NO		YES	NO
DIABETES…………………	❑	❑	TUBERCULOSIS………………	❑	❑	ENDOCRINE OR THYOID………………………	❑	❑
PNEUMONIA………………	❑	❑	ANEMIA…………………………	❑	❑	PROLONGED BLEEDING………………………	❑	❑
HEART TROUBLE…………	❑	❑	EPILEPSY………………………	❑	❑	LIVER INVOLVEMENT……………………………	❑	❑
RHEUMATIC FEVER……..	❑	❑	ASTHMA…………………………	❑	❑	FAINTING OR DIZZINESS………………………	❑	❑
BONE DISORDERS………	❑	❑	KIDNEY INVOLVEMENT………	❑	❑	NERVOUS DISORDERS…………………………	❑	❑

	YES	NO
ARE YOU IN GOOD HEALTH?..	❑	❑
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS___________________		
____		
HAVE YOU EVER BEEN TREATED FOR OSTEOPOROSIS?...	❑	❑
DO YOU HAVE ANY HISTORY OF MAJOR ILLNESS?..	❑	❑
____		
LIST ANY ALLERGIES OR DRUG SENSITIVITIES____		
____		
DO YOU WEAR CONTACT LENSES?..	❑	❑

PATIENT'S PHYSICIAN__________________________________ LAST SEEN___________________________

DENTAL HISTORY

	YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?...	❑	❑
DO YOU HAVE ANY CLICKING OR DISCOMFORT IN JAW JOINTS NEAR THE EARS?........................	❑	❑
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH?...........................	❑	❑
HAVE YOU HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS OR TREATMENT?........................	❑	❑
DO YOU CLENCH OR GRIND YOUR TEETH?..	❑	❑
ARE YOU ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS?...	❑	❑
DO YOU HAVE ANY CONGENITAL ABNORMALITIES?..	❑	❑

PATIENT'S DENTIST___________________________________ LAST SEEN ___________________________

LIST INTERESTS____