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	☐	☐	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
IS THE PATIENT IN GOOD HEALTH?	☐	☐
DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS?	☐	☐
DOES THE PATIENT WEAR CONTACT LENSES?	☐	☐
HAVE TONSILS AND ADENOIDS BEEN REMOVED?	☐	☐
HAS PATIENT REACHED PUBERTY?	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS_____

_____

_____

LIST ANY ALLERGIES OR DRUG SENSITIVITIES_____

_____

WHAT AGE?_____

GROWTH IN THE PAST 6 MONTHS_____

HEIGHT: PATIENT'S_____ MOTHER'S_____ FATHER'S_____

PATIENT'S PHYSICIAN:_____ LAST SEEN:_____

DENTAL HISTORY

	YES	NO
HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH?	☐	☐
HAS THE PATIENT EVER SUCKED A THUMB OR FINGER?	☐	☐
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?	☐	☐

UNTIL WHAT AGE?_____

PATIENT'S DENTIST_____ LAST SEEN _____

LIST SPORTS AND INTERESTS_____