



PATIENT INFORMATION \*\*PLEASE PRINT (BLACK/BLUE INK) \*\*

PATIENT'S FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN# \_\_\_\_\_
STREET ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_
Nickname \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_
If student, name of school/college: \_\_\_\_\_ Grade \_\_\_\_\_
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_
Length of Employment \_\_\_\_\_ Work Address \_\_\_\_\_ Work # \_\_\_\_\_
Parent/Guardian or Spouse Name \_\_\_\_\_
Notify in case of emergency \_\_\_\_\_ Phone # \_\_\_\_\_
Whom may we thank for referring you to our office? \_\_\_\_\_

Siblings or Immediate Family Members that received treatment in this office:

CONTACT INFORMATION

We would like to send you appointment reminders, information about treatment, payment, insurance and other communications. Please tell us how you would like us to communicate with you.

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_
CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

[ ] By checking this box, I consent to the following: The practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of auto dialing. This is optional and not required to receive care at our office.

FINANCIAL/INSURANCE INFORMATION

Do you have orthodontic insurance coverage? Y / N If YES, fill out Insurance Information Sheet.

Person(s) Responsible for Account \_\_\_\_\_
Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_
Address (if different from patient) \_\_\_\_\_ Marital Status \_\_\_\_\_
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_
Length of Employment \_\_\_\_\_ Work Address \_\_\_\_\_ Work # \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize and consent to any x-rays, examination and treatment rendered under the direct or indirect supervision of the orthodontist as they may deem necessary. I also understand this office may request pertinent medical, dental and financial history (credit report) related to the anticipated treatment. This authorization will remain in effect until cancelled by writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

DENTAL HISTORY					
PATIENT'S DENTIST: _____			DATE OF LAST VISIT: _____ X-RAYS TAKEN: Y / N		
DENTIST'S ADDRESS: _____			ANY DENTAL CONCERNS?		
ANY PRIOR ORTHODONTIC TREATMENT: Y / N			ARE YOU UNDER THE CARE OF ANY OTHER DENTAL SPECIALIST? Y / N		
ORTHODONTIST: _____			SPECIALIST'S NAME: _____		
EXPLAIN:			EXPLAIN:		
PAST FACIAL, HEAD OR NECK TRAUMA: Y / N			SPEECH THERAPY: Y / N		
PAST DENTAL TRAUMA: Y / N			How often do you brush your teeth?		
Have you ever been told you have TMD?			Y	N	
Do you floss regularly?		Y	N	Do you snore?	
Do your gums bleed?		Y	N	Do you ever clench your teeth?	
Have you had unusual bleeding with previous extractions surgery?		Y	N	Do you have any pain or discomfort, in the jaw-joint, face or neck?	
Can you chew on both sides of your mouth?		Y	N	Is there a history of gum disease?	
Are your teeth painful?		Y	N	Are you aware of any gum recession?	
Are you aware of your jaws making clicking, popping or cracking noises?		Y	N	Have you ever had periodontal treatment?	
HABITS					
THUMB SUCKING		Y	N	MOUTH BREATHER	
FINGER SUCKING		Y	N	USE OF TOBACCO	
NAIL BITTER		Y	N	OTHER:	
HEALTH HISTORY					
PATIENT'S PHYSICIAN: _____			PHYSICIAN'S PHONE: _____		
ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE: Y / N			HOSPITALIZED IN THE PAST 3 YEARS: Y / N		
REASON(S): _____			CURRENT MEDICATION(S) OR TREATMENT DRUGS: _____		
Do you have any mental illness or developmental disability that requires special attention?					
ALLERGIES TO ANY DRUGS OR MEDICINE? Y (PLEASE LIST) / N					
Have you been in any other institutions (weight reduction, drug or alcohol treatment, psychiatric, or other) in the past 3 years?		Y	N	Do you occasionally use or take recreational drugs?	
Have you had a blood transfusion in the past 3 years?		Y	N	Have you had prolonged coughing or coughed up blood?	
Do you perspire excessively at night?		Y	N	Have you ever been tested for hepatitis or AIDS?	
Do you have persistent diarrhea or recent weight loss?		Y	N	Results were: Negative (no virus) ____ Positive (virus present) ____	
Have you ever had damage or artificial heart valves, including heart murmur, rheumatic heart disease, or scarlet fever?		Y	N	Have you had canker sores, cold sores, fever blisters or other sores on your lips, tongue, gums, genitals or body in the past 3 years?	
Do you have a purplish rash or persistent purplish bruise(s)?		Y	N	Do you require any pre-medication for dental or other treatment?	
Are you pregnant? (if applicable)		Y	N	Please explain:	
Check any of the following which you have had or now have (provide date to the left)					
<input type="checkbox"/> _____ AIDS	<input type="checkbox"/> _____ cardiovascular disease	<input type="checkbox"/> _____ heart trouble	<input type="checkbox"/> _____ organ transplant		
<input type="checkbox"/> _____ allergies	<input type="checkbox"/> _____ chicken pox	<input type="checkbox"/> _____ hepatitis	<input type="checkbox"/> _____ osteoporosis		
<input type="checkbox"/> _____ anemia	<input type="checkbox"/> _____ chronic cough	<input type="checkbox"/> _____ herpes	<input type="checkbox"/> _____ psychiatric treatment		
<input type="checkbox"/> _____ arthritis	<input type="checkbox"/> _____ congenital heart lesions	<input type="checkbox"/> _____ high blood pressure	<input type="checkbox"/> _____ shortness of breath		
<input type="checkbox"/> _____ artificial heart valves	<input type="checkbox"/> _____ cytomegalovirus (CMV)	<input type="checkbox"/> _____ immune disorders	<input type="checkbox"/> _____ sinus trouble		
<input type="checkbox"/> _____ artificial joints	<input type="checkbox"/> _____ diabetes	<input type="checkbox"/> _____ jaundice	<input type="checkbox"/> _____ stroke		
<input type="checkbox"/> _____ asthma	<input type="checkbox"/> _____ dizziness, fainting spell	<input type="checkbox"/> _____ kidney treatment	<input type="checkbox"/> _____ tuberculosis		
<input type="checkbox"/> _____ bacteria endocarditis	<input type="checkbox"/> _____ epilepsy	<input type="checkbox"/> _____ measles or mumps	<input type="checkbox"/> _____ sexually transmitted diseases		
<input type="checkbox"/> _____ cancer treatment	<input type="checkbox"/> _____ glaucoma	<input type="checkbox"/> _____ mitral valve prolapse	<input type="checkbox"/> _____ chemotherapy		
<input type="checkbox"/> _____ cardiac pacemaker	<input type="checkbox"/> _____ heart murmur	<input type="checkbox"/> _____ mononucleosis	<input type="checkbox"/> _____ radiation therapy		