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PATIENT INFORMATION (Please Print)

Date ____________

Patient's Name ____________ Last ____________ First ____________ Prefers to be called

Address ____________ Street ____________ City ____________ Zip Code

Phone (______) ____________

Patient's Date of Birth ____________ Month / Day / Year Age M ☐ F ☐

Referred By ____________

E-mail ____________

Cell Phone (______) ____________

Dentist ____________

Physician ____________

School ____________

Siblings ____________

Emergency Contact ____________

Phone (______) ____________

Mother's Name ____________

Date of Birth ____________

Social Security Number ____________

Home Address (if different from pt.) ____________

Occupation ____________

Employer ____________

Work Address ____________

Phone (______) ____________ Home (______) ____________ Work

Father's Name ____________

Date of Birth ____________

Social Security Number ____________

Home Address (if different from pt.) ____________

Occupation ____________

Employer ____________

Work Address ____________

Phone (______) ____________ Home (______) ____________ Work

Person Responsible for Account (if person is not listed above please give address, phone & relationship) ____________

Is patient covered by orthodontic insurance? Yes ☐ No ☐ **If Yes, please complete the following information:**
IF YOU HAVE COVERAGE FROM MORE THAN ONE COMPANY, PLEASE GIVE ALL INFORMATION FOR EACH COMPANY.

1. ____________
Name of Insurance Company ____________ Name of Policy Holder(s) ____________ SS# ____________ Date of Birth

Policyholder(s) Employer(s) ____________ Union Local Number(s) ____________ Employer Group Number(s)

2. ____________
Name of Insurance Company ____________ Name of Policy Holder(s) ____________ SS# ____________ Date of Birth

Policyholder(s) Employer(s) ____________ Union Local Number(s) ____________ Employer Group Number(s)

DENTAL HISTORY

Date of last dental cleaning ____________ How often? ____________

Family history of orthodontic problems ____________

Are there any habits which have caused the teeth to move? nail or lip biting ☐ thumb sucking ☐ clenching ☐ grinding ☐

What is your main concern? ____________

	YES	NO
Any injuries to face, mouth, or teeth in the past?	☐	☐
Does the patient have any speech problems?	☐	☐
Are there any missing or extra permanent teeth?	☐	☐

List any musical instruments played by mouth ____________

	YES	NO
Does patient have sore or sensitive teeth?	☐	☐
Has patient ever had any orthodontic treatment?	☐	☐

	YES	NO
Is patient self-conscious about appearance of teeth?	☐	☐
Has a dentist shown patient how to clean his/her teeth?	☐	☐

How often does patient brush his/her teeth? ____________

List type of toothbrush (hard, medium, soft) ____________

List any other aids (floss, stimulant, water spray device, rubber tip, or toothpick) and how often used ____________

Additional general dental information: ____________

MEDICAL HISTORY

Date of last medical care ____________________

Has patient been in a hospital in the last 2 years? ☐ YES ☐ NO Reason: ____________________

Health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does your child have a reaction to any of the following? (Please check and describe fully under remarks):

	YES	NO
1. **ALLERGIES**		
a. Penicillin	☐	☐
b. Other Antibiotics ____________	☐	☐
c. Others ____________	☐	☐
2. Arthritis	☐	☐
3. Asthma	☐	☐
4. Blood disease or Abnormal Bleeding Problems	☐	☐
a. Anemia	☐	☐
b. Clotting Problems	☐	☐
c. Other Blood Disorders	☐	☐
5. Diabetes	☐	☐
Taking medications ____________	☐	☐
If yes, please list ____________		
6. Chest pains, ankle swelling, or shortness of breath?	☐	☐
7. Epilepsy	☐	☐
8. Fainting	☐	☐
9. Glandular disease (thyroid, etc.)	☐	☐
10. Heart Disease	☐	☐
11. Heart Murmur	☐	☐
12. Rheumatic Fever	☐	☐
13. High Blood Pressure	☐	☐
14. Low Blood Pressure	☐	☐
15. Kidney Disease	☐	☐
16. Liver Disease, Hepatitis, Jaundice	☐	☐
17. AIDS / HIV +	☐	☐
18. Radiation Treatment	☐	☐
19. Respiratory Disease	☐	☐
20. Stomach or Duodenal Ulcers	☐	☐
21. Tumor History	☐	☐
22. Psychiatric Treatment	☐	☐
23. Emotional / Behavioral Problems ____________	☐	☐
24. Other Medical Conditions ____________	☐	☐

25. Has patient had excessive bleeding requiring treatment? ____________	☐	☐
26. Is patient taking medicine, drugs or pills regularly? ____________	☐	☐
27. Has patient experienced any unfavorable reaction to previous dental treatment? ____________	☐	☐
28. DOES PATIENT REQUIRE PRE-MEDICATION, BASED ON PHYSICIAN INSTRUCTION/PERSONAL REFERENCE, PRIOR TO DENTAL TREATMENT? IF SO, NAME OF MEDICATION ____________	☐	☐

29. Is there any other information we should know? ____________________

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ACKNOWLEDGEMENT AND AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient named above. I also acknowledge full responsibility for the payment of such services and agree to pay for them.

Signed ____________________ Date ____________

Patient, Parent or Guardian (Must be 18 years or older)

For Office Use

Treatment Time ____________

Treatment Fee ____________

Initial Fee ____________ Monthly ____________ Contract Sent ____________