

### Confidential Patient Information

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

Patient's Name: \_\_\_\_\_  
Last First Nickname Marital Status

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

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

How long at this address: \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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

Spouses Name: \_\_\_\_\_  
Last First Middle

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

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Orthodontic Insurance Information

Insured's Name: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Do you have dual coverage?  Yes  No

Insured's Employer: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's Soc. Sec. #: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group No.: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Insured's Birthdate: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

### Emergency Information

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

Complete Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

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

Updates (date & initial) \_\_\_\_\_

## Medical Information

Patient's Physician: \_\_\_\_\_

Is patient in good health?     Yes     No

Does patient have any history of major illness? \_\_\_\_\_

Has patient been treated by a Physician for: (Check where appropriate)

<input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Hepatitis <input type="checkbox"/> Endocrine Problems <input type="checkbox"/> Bone Disorders	<input type="checkbox"/> H.I.V. <input type="checkbox"/> Heart Problems <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Presently Pregnant <input type="checkbox"/> Removal of Tonsils (age) _____	<input type="checkbox"/> Liver Problems <input type="checkbox"/> Allergies <input type="checkbox"/> Emotional Problems <input type="checkbox"/> Epilepsy <input type="checkbox"/> Prolonged Bleeding
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Is patient taking prescription medications?                       Yes     No

Is patient required to take pre-med for dental procedures?     Yes     No

(If yes please list) \_\_\_\_\_

Any allergies? \_\_\_\_\_

## Dental Information

Name of general dentist: \_\_\_\_\_

	Yes	No	More Information
Has patient had a recent dental exam?			
Injuries to mouth or teeth?			
Clicking or pain when opening jaws?			
Has jaw ever locked open?			
Difficulty chewing or eating?			
Teeth grinding or clenching?			
Previous orthodontic treatment? When?			
Frequent mouth sores?			
Is patient a mouth breather?			
Has anyone else in the family worn braces?			
High intake of sweets?			
Any traumatic dental experiences?			

Hobbies/Interests: \_\_\_\_\_

Siblings/Children: \_\_\_\_\_

Friends that are patients of ours: \_\_\_\_\_

Comments or suggestions? \_\_\_\_\_