

Confidential Responsible Party Information

Date: _____

Name: _____
Last First Middle Marital Status

Residence: _____
street City State Zip Code

Mailing Address: _____
street City State Zip Code

How long at this address? _____ Home Phone: _____ Work Phone: _____

Previous Address (if less than 3 yrs.) _____

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ No. years Employed: _____

Social Security #: _____ Birthdate: _____ Work Phone: _____

Confidential Patient Information

Patient's Name _____ Gender: M F
Last First Middle Nickname

Address: _____
street City State Zip Code

Home Phone: _____ Birthdate: _____ Social Security #: _____

Responsible Party E-mail Address: _____

Patient's E-mail Address: _____

Whom may we thank for referring you to our office? _____

Orthodontic Insurance

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insurance Company: _____ Group No.: _____ Ins. Co. Phone #: _____

Insurance Co. Address: _____

Do you have dual coverage? Yes No If yes:

Insured's Name: _____ Insured's Soc. Sec. #: _____

Insurance Co.: _____ Group No.: _____ Local No.: _____

Insurance Co. Address: _____

Insured's Employer: _____

Emergency Information

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship _____

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

Signature (Parent's signature if minor) _____

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"/> H.I.V. | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> Prolonged Bleeding |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Removal of Tonsils (age) _____ | |

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? _____

If patient is a minor: Has puberty been reached? (menstruation or voice change) Yes No

If within the last 2 years, when? _____

Is patient adopted? Yes No

Patent's attitude toward orthodontic treatment? Eager Complacent Antagonistic

Comment: _____

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?			
Has dentist removed primary (baby) teeth?			
Has dentist removed permanent teeth?			
Thumbsucking or finger habits?			
Frequent mouth sores?			
Is patient a mouth breather?			
Has anyone else in the family worn braces?			
High intake of sweets?			
Any traumatic dental experiences?			

School/Grade: _____

Hobbies/Interests: _____

Siblings/Children: _____

Friends that are patients of ours: _____

Comments or suggestions? _____