Date _____

Confidential Patient Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____ Email _____
Street City State Zip

How long at this address? _____ Previous Address? (if less than 3 yrs) _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Birthdate _____

Employer _____ Occupation _____ # Years Employed _____

Spouse's Name _____
Last First Middle

Employer _____ Occupation _____ # Years Employed _____

Social Security # _____ Birthdate _____ Daytime Phone _____

Orthodontic Insurance Information

Policy Holder's Name _____ and Social Security # _____

Policy ID# _____ Birthdate _____

Insured's Address _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Do you have dual coverage? No ☐ Yes ☐ If Yes: _____

Policy Holder's Name _____ and Social Security # _____

Policy ID# _____ Birthdate _____

Insured's Address _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

Emergency Information

Name of the nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship of Relative _____

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

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

Signature (Parent's signature if a minor) _____

Updates (date & initial) _____

Medical Information

Patient's Physician _____

Is patient in good health? ☐ Yes ☐ No

Does patient have any history of major illness? ☐ Yes ☐ No If yes, please specify _____

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

- ☐ **Asthma**
- ☐ **Anemia**
- ☐ **Diabetes**
- ☐ **Hepatitis**
- ☐ **Endocrine Problems**
- ☐ **Bone Disorders**
- ☐ **H.I.V.**
- ☐ **Heart Problems**
- ☐ **Rheumatic Fever**
- ☐ **Kidney Problems**
- ☐ **Presently Pregnant**
- ☐ **Removal of Tonsils (age)**
- ☐ **Liver Problems**
- ☐ **Allergies**
- ☐ **Emotional Problems**
- ☐ **Epilepsy**
- ☐ **Prolonged Bleeding**

Is patient taking prescription medications? ☐ Yes ☐ No

(If Yes, please list) _____

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

(If Yes, please list) _____

Has patient taken medications for osteoporosis? ☐ Yes ☐ No

If yes, please specify: _____

Any allergies? _____

Dental Information

Name of general dentist: _____

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

Hobbies / Interests: _____

Siblings / children: _____

Friends that are patients of ours: _____

Comments or suggestions? _____

Confidential (For record and pretreatment evaluation).