



ORTHODONTICS

PATIENT INFORMATION

GENERAL DENTIST

Patient _____
Last First Initial

Name _____
Last First Initial

Nickname: _____

Street Address _____

Street Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Phone # _____ Last Visit _____

Home Phone # _____

REFERRAL SOURCE

Alternate # _____

Who may we thank for referring you here?

Email Address for Appointment Reminders:

DENTAL INSURANCE INFORMATION

Date of Birth _____ Age _____ Male _____ Female _____

PRIMARY:

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Self / Father / Mother / Spouse / Other (please circle one)

Emergency Contact _____

Employee's Name _____

Relationship _____

Employer's Name _____

Phone Number _____

Work # _____ Cell # _____

Date of Birth _____ SS# _____

RESPONSIBLE PARTY INFORMATION

Dental Insurance Company _____

(This is the person that brought the patient in today)

Insurance Address _____

Self / Father / Mother / Spouse / Other (please circle one)

City _____ State _____ Zip _____

Name _____

Phone # _____ Group # _____

Home # _____ Cell # _____

SECONDARY:

Date of Birth _____ SS# _____

Self / Father / Mother / Spouse / Other (please circle one)

Address (if different than above)

Employee's Name _____

Years at address _____ Own or rent _____

Employer's Name _____

Employer Name _____

Work # _____ Cell # _____

Years at Employer _____ Work # _____

Date of Birth _____ SS# _____

Occupation _____

Dental Insurance Company _____

Single _____ Married _____ Widowed _____ Separated _____ Divorced _____

Insurance Address _____

Spouse's Name: _____

City _____ State _____ Zip _____

Phone # _____ Group # _____

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DENTAL HISTORY

What would you like orthodontics to accomplish? _____

Has the patient ever been evaluated for or had orthodontic treatment before? YES NO

Have there been any injuries to the face, mouth, teeth, or chin? YES NO

If yes, please explain _____

Has the patient been informed of any missing or extra PERMANENT teeth? YES NO

If yes, please explain _____

Has the patient ever had any pain / tenderness in the jaw joints (TMJ/TMD)? YES NO

Does the patient have any speech problems? YES NO

If yes, please give the name of the speech specialist (if applicable) _____

Does your child have any special needs or sensitivities? YES NO

If yes, please explain _____

Does the patient have a history of thumb / finger sucking? YES NO

How does the patient relate to new experiences? _____

We would like to make your visit as comfortable as possible, so if there is anything else that you would like to add regarding you or your child, please feel free to note them here or tell us at anytime:

MEDICAL HISTORY

Is the patient currently under the care of a physician and / or specialist? YES NO

If yes, please explain _____

Physician Name: _____ Physician Phone: _____

Specialist Name _____ Specialist Phone: _____

How is the patient's current physical health? _____

Is the patient taking any prescription / over-the-counter drugs? YES NO

If yes, please list _____

Do you take any medications for your bones (oral or IV)? YES NO

Has the patient ever had any of the following diseases or medical problems?

Heart Disease YES NO

Abnormal Bleeding YES NO

Heart Murmur or Prosthetic Valve YES NO

Does the patient require Antibiotic Prophylaxis for dental procedures? YES NO

Does the patient have any allergies? YES NO

Latex Allergy? YES NO

Nickel Allergy? YES NO

Please list any drug allergies _____

Has the patient ever been hospitalized? YES NO

If yes, please explain _____

Are you pregnant? YES NO

Any prior medical experience that would be useful for us to know? _____

I understand the information I have given is correct to the best of my my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in the medical status.

If this office accepts insurance, I understand that I am responsible for payments of services rendered and also for any co-payment and / or deductibles that my insurance does not cover. I further understand that if my insurance is cancelled or refuses payment for any reason that I am responsible for the balance of the payment in a timely manner. I/we understand that, where appropriate, credit reports may be attained.

Signature of Adult Patient or Parent/Guardian Date

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