



Patient Information

Name _____
Last First Middle Sex Marital Status

Address _____
Street City State Zip

Birthdate _____ E-mail _____ Social Security# _____
MM-DD-YYYY 999-99-9999

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____
999-999-9999 999-999-9999 999-999-9999

Employer _____ Occupation _____ No. Years Employed _____

General Dentist _____ Last Visited _____

Who may we thank for referring you to our office _____

Spouse / Additional Contact Information

Name _____
Last First Middle Marital Status

Address _____
Street City State Zip

Birthdate _____ E-mail _____ Relationship to Patient _____
MM-DD-YYYY

Home Phone _____ Cell Phone _____ Work Phone _____ ext. _____
999-999-9999 999-999-9999 999-999-9999

Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Policy Owner's Name _____ Policy Owner's Social Security # _____
999-99-9999

Policy Owner's Birthdate _____ Relationship to Patient _____
MM-DD-YYYY

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Secondary Insurance

Policy Owner's Name _____ Policy Owner's Social Security # _____
999-99-9999

Policy Owner's Birthdate _____ Relationship to Patient _____
MM-DD-YYYY

Policy Owner's Employer _____ Employer's Address _____

Insurance Company _____ Group No. (plan, local, or policy) _____

Insurance Co. Address _____ Insurance Phone No. _____

Medical History

Are you under the care of a physician? Yes No If Yes, explain _____

Physician _____ Phone _____ Last Visit _____

Address _____

Are you pregnant Yes No If so how many weeks _____

What are the main concerns that you would like orthodontics to accomplish? _____

Have you ever been evaluated for orthodontic treatment? _____

Have your tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to : (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if yes, explain _____

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Do you require antibiotics before dental treatment? Yes No

Does/Has the patient ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Fingers Sucking

Does the patient have speech problems? Yes No if Yes, explain _____

Are you allergic to any of the following?	
Aspirin	Erythromycin
Codeine	Penicillin
Tetracycline	Latex
Any Metals/Plastics	
Other Allergies/Sensitivites:	

List all drugs you are currently taking
<div style="border: 1px solid black; width: 90%; margin: auto; min-height: 100px;"></div>

Have you been treated for any of the following?	
Arthritis	Heart Condition
Asthma	Nervous Disorder
Blood Disorder	Tuberculosis
Cancer	Other:
Diabetes	_____
Epilepsy	_____

Signature

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

I hereby authorize the release of any information related to insurance claim. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

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

Name of person filing out this form _____ Date _____