

Date \_\_\_\_\_

***PATIENT INFORMATION***

**Patient's Name:** \_\_\_\_\_ **Sex:** \_\_\_\_\_  
Last First Middle

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

**Home Phone:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Soc. Security#** \_\_\_\_\_

If Patient is a minor, give parent's or guardian's name \_\_\_\_\_

Name of school currently attending: \_\_\_\_\_

Whom may we thank for referring you to our office \_\_\_\_\_

**General Dentist Name:** \_\_\_\_\_ **Date of last visit** \_\_\_\_\_

**Email:** \_\_\_\_\_

***RESPONSIBLE PARTY INFORMATION***

**Name:** \_\_\_\_\_  
First Middle Last Marital Status

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

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

**Cell Phone:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Social Security #** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **#Yrs. Employed** \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_  
First Middle Last

**Mailing Address** (If different from above) \_\_\_\_\_  
Street City State Zip

**Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_ **# Yrs. Employed** \_\_\_\_\_

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

***INSURANCE INFORMATION***

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

**Insurance Company** \_\_\_\_\_ **Group#** \_\_\_\_\_ **Local#** \_\_\_\_\_

**Insurance Co. Address** \_\_\_\_\_ **Phone#** \_\_\_\_\_

Do you have dual coverage?  Yes  No If yes:

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

**Insurance Company** \_\_\_\_\_ **Group #** \_\_\_\_\_ **Local#** \_\_\_\_\_

**Insurance Co. Address** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Insured's Employer** \_\_\_\_\_

**MEDICAL HISTORY**

1. Please check if patient has or had any problems with the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Latex Allergy     | <input type="checkbox"/> Metal Allergy               | <input type="checkbox"/> Gagging                  |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Heart Disease            |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Earaches                    | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Emotional Problems          | <input type="checkbox"/> Herpes                   |
| <input type="checkbox"/> Blood Disease     | <input type="checkbox"/> Endocrine (hormone)problems | <input type="checkbox"/> Tonsilitis               |
| <input type="checkbox"/> Bone Disorders    | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Women: Are you pregnant? |

2. Do you have any allergies or drug sensitivities?  Yes  No

If yes, to what? \_\_\_\_\_

3. Have you had rheumatic fever, congenital heart lesions, of damaged artificial heart valves?  Yes  No

If yes, to what? \_\_\_\_\_

4. Do you have a heart murmur?  Yes  No

5. Do you take antibiotic premedication when you see a dentist?  Yes  No

If yes, what kind \_\_\_\_\_

6. Is there any condition affecting the patients health others than those mentioned?  Yes  No

If yes, list \_\_\_\_\_

7. Do you take any medications for osteoporosis such as Fosamax, Boniva or Actonel  Yes  No

If yes, list \_\_\_\_\_

**DENTAL HISTORY**

8. Please check if patient has or had any of the following:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Clenching/grinding teeth | <input type="checkbox"/> Missing or Extra teeth  | <input type="checkbox"/> Periodontal (gum) disease     |
| <input type="checkbox"/> Jaw Joint problems       | <input type="checkbox"/> Thumb or Finger sucking | <input type="checkbox"/> Tongue Thrust/Speech problems |

9. Does the patient have more than normal headaches or earaches?  Yes  No

10. Has the patient received previous orthodontic treatment?  Yes  No

11. Has anyone in your family had orthodontic treatment?  Yes  No Who? \_\_\_\_\_

12. If patient is a minor list **name** and **age** of siblings. \_\_\_\_\_

13. Would patient be willing to wear braces if necessary, to correct the problem? \_\_\_\_\_

14. Is there any reason why treatment should not be started immediately? \_\_\_\_\_

15. What is the primary reason for seeing an orthodontist? \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you. \_\_\_\_\_ Relationship \_\_\_\_\_

Complete Address \_\_\_\_\_ Phone # \_\_\_\_\_