

Patient Name _____ Home Phone# _____ Date of Birth _____

Address _____
street city state zip

Employer _____ Business Phone _____ Cell Phone _____

Spouse _____ Date of Birth _____

Employer _____ Business Phone _____ Cell Phone _____

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

Children in family Yes No Names and Ages: _____

Children in treatment with us? Yes No Names and Ages: _____

Insurance Information

Financially Responsible Party _____ Do you have orthodontic insurance? Y / N

Insurance Company _____ Phone # _____

Subscriber Name: _____ DOB: _____ Subscriber SS#: _____

Subscriber ID#: _____ Group # _____

Secondary Insurance? _____ Subscriber Name: _____ DOB _____

Insurance Company _____ Subscriber ID#: _____ Group # _____

Dental History

Dentist's Name: _____ Frequency of visits: _____ Last visit: _____

1. Have there been any injuries to the face, mouth, or teeth? _____ Explain: _____
2. Is the patient a mouth breather? _____
3. Have you been informed of any missing or extra teeth? _____
4. Has an orthodontist been consulted previously? _____
5. Has the patient ever had jaw pain _____, clicking _____, or locking in the jaw joint _____
5. Does the patient grind/clinch teeth? _____

Reason for orthodontic evaluation: _____

Medical History

Doctors Name: _____ Phone Number: _____

1. Is the patient in good health? _____ If NO, explain _____
2. Does the patient have a history of any serious or major illness? _____ Explain _____
3. Is the patient presently under medical care? _____ For what? _____
4. Does the patient have any allergies? _____ Allergic to _____
5. Does the patient have a tendency to colds? _____ Sore throats? _____ Ear infections? _____
6. Have tonsils/adenoids been removed? _____ Age _____
7. List any drugs or medication now being taken: _____
8. WOMEN: Are you pregnant? _____
9. Check any of the following conditions which the patient has been or is being treated for:

Diabetes _____	Tuberculosis _____	Hormone problems _____
Pneumonia _____	Anemia _____	Prolonged bleeding _____
Heart Trouble _____	Epilepsy _____	Fainting or Dizziness _____
Rheumatic Fever _____	Asthma _____	Nervous disorder _____
Bone disorders _____	Kidney problems _____	Hepatitis _____

I understand, where appropriate, a credit report will be obtained: _____