Patient Information

Patient's Name____
Date of Birth_____________________ Age________ Sex________ Social Security No._____________
Address____
Home Phone________________________ Cell Phone_____________________________________
Employer____________________________________ Occupation_________________________________
Patient's Dentist_________________________ Patient's Physician____________________________
Hobbies____________________________________ Billing Party Email Address ___________________
Number of siblings/children_____________________ Patients School___________________________
If patient is a minor, give parent's or guardian's names_______________________________________

Responsible Billing Party Information

Name____ Marital Status________________
Mailing Address____
Home Phone________________ Cell Phone________________ Work Phone___________________
Social Security No._______________ Birthdate___________ Relationship to Patient_____________
Employer___________________________________ Occupation__________________________________

Spouse's Name____
Social Security No._______________ Birthdate___________ Relationship to Patient_____________
Employer___________________________________ Occupation__________________________________

Insurance Information

Primary Subscriber
Name____________________________ Social Security No.______________ Date of Birth__________
Insurance Company__________________________ Group No.____________ ID No.______________
Subscriber's Employer____
Subscriber's Address and Phone____

Secondary Subscriber
Name____________________________ Social Security No.______________ Date of Birth__________
Insurance Company__________________________ Group No.____________ ID No.______________
Subscriber's Employer____
Subscriber's Address and Phone____
(If different from above)

Patient's Medical History

Have you been under the care of a physician in the last two years?______________________________
Have you had any recent operations? ___Yes ___No
Have you been recently hospitalized? ___Yes ___No
Have you ever been told that you have an allergy to latex? ___Yes ___No
Have you ever been told that you have metal allergies? ___Yes ___No
Have you ever had an allergic reaction to, or been told not to use, any medication, antibiotics, or pain relievers?
___Yes ___No If yes, please explain:____
Please list any medications you are presently taking:____
Have you ever taken a bisphophonate? ___Yes ___No
Are you pregnant? ___Yes ___No

Have you ever had or do you now have any of the following (Check all that apply):		
___Prolonged Bleeding ___Blood Disorders ___Anemia ___Diabetes ___Heart Problems ___Epilepsy ___Rheumatic Fever ___Arthritis	___Birth Defects ___Cancer ___Asthma ___Allergies ___Fainting or Dizziness ___Nervous Disorders ___Endocrine Problems ___Liver Problems	___Bone Disorders ___Tuberculosis ___Hepatitis ___Aids or HIV ___Learning disability ___Other_________________

Patient's Dental History

Do you have any of the following (Check all those that apply):
___Any family members who have had orthodontics? Explain:____________________________________
___Teeth sensitive to hot/cold?
___Injuries to your face, jaw, mouth or teeth?
___Bleeding gums, bad taste in mouth?
___Root canals, crowns, or bridges?
___Suck your thumb and/or fingers?
___Do you clench your teeth? When?__________________ How often?_____________________________
___Do you grind your teeth? When?__________________ How often?_____________________________
___Do you have chronic headaches? Describe where and how often:_______________________________
___Any clicking, popping or pain of the jaw, joints (TMJ)?
Which side? ____________________ When do you notice it?___________________________________
___Any missing teeth or extra teeth?
___Trouble chewing?
___Are you aware of a tongue thrust or tongue habit?
___Do you breathe more easily through your mouth?
___Do you snore?
___Have you had a history of ear, nose, or throat infections? (Circle those which apply)
___Have you had your tonsils or adenoids removed? (Circle those which apply)
When and by whom? ____

How often do you see your dentist?____
Date of most recent dental exam____
Have you ever had an orthodontic exam?________ When and with whom?________________________
What was recommended?____
Have you ever had orthodontic treatment?________ When and with whom?______________________
What type of treatment did you receive?____

What about your teeth or smile would you like to see changed?
____
____

How did you hear about us? ___Dentist ___Friend ___Work ___Ads ___Internet ___Other_____________

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

I understand that, where appropriate, credit reports may be obtained and will be kept confidential.

Signature (Parent/guardian if patient is a minor) ____