PATIENT INFORMATION Appointment Date: ____________________

Name: ____________________________ Preferred greeting: ________________
Date of birth: ______________________________ Sex: _____
Address: _______________________________________
City: ___________________________________ State: ________ Zip: _____________
Phone: _____________________ ○Home ○Cell ○Work Phone: _____________________ ○Home ○Cell ○Work
Phone: _____________________ ○Home ○Cell ○Work
Email: ________________________________
School __________________________________ Grade ___________
Father's name ____________________________ Employer: __________________________ Work Phone: ____________
Mother's name __________________________ Employer: __________________________ Work Phone: ____________
Marital status of parents: ○ Married ○ Separated ○ Divorced ○ Single ○ Widowed
Whom may we thank for referring you to our office? _______________________________

RESPONSIBLE PARTY

Person responsible for financial matters:
Name: _____________________________ Phone: ____________________ Phone 2: _____________________
Address: ______________________________________ City: __________________ State: ________ Zip: ___________
Employer: _________________________ Email: _______________________ Social Security # : ________________

INSURANCE INFORMATION

If you have orthodontic insurance, please provide us with your card *OR* complete the following:

Name of insured (primary**)**: _________________________SS# : ________________ Date of birth: ______________
Insurance Co: ____ Group # :____________________
Employer: ________________________ Ins. Co. address: ____
Ins. Co. Phone: ___________________

Name of insured (secondary**)**: _________________________SS# : ________________ Date of birth: ____________
Insurance Co: ____ Group # :____________________
Employer: ________________________ Ins. Co. address: ____
Ins. Co. Phone: ___________________

CONCERNS

Describe the reason for the consultation: ____
Is the patient aware of the orthodontic problem? ○ Yes ○ No
Has the patient had previous orthodontic treatment? ○ Yes ○ No Previous orthodontic consultation? ○ Yes ○ No
Which of the following best describes the patient's interest in orthodontic treatment?
○ Patient wants treatment ○ Willing if treatment is necessary ○ Unwilling, but agrees

DENTAL HISTORY

Dentist: ____________________________ Date of last dental visit: ______________________

Have there been any injuries to the face, mouth or teeth? ○ Yes ○ No

Has the patient ever sucked a thumb or fingers? ○ Yes ○ No

Is the patient a mouth breather? ○ Yes, while awake ○ Yes, while asleep ○ No

Does the patient grind his/her teeth? ○ Yes ○ No

Does the patient have a speech problem? ○ Yes ○ No

Does the patient play a musical instrument? ○ Yes ____________________________ ○ No

How often does the patient brush his/her teeth? ○ Once a day ○ Twice a day ○ Several times a day ○ Occasionally

Have you been informed of any missing or extra permanent teeth? ○ Yes ○ No

Has any member of the family had orthodontic treatment? ○ Yes ____________________________ ○ No

MEDICAL HISTORY

Physician: ____

Does the patient have any history of major illness? ○ Yes ○ No

If yes, please explain ____

Has the patient ever been under the care of a physician for illness? ○ Yes ○ No

If yes, please explain ____

Please place a check beside the medical conditions which the patient has now or had previously?

○ Anemia	○ Cancer	○ Glaucoma	○ Kidney disease
○ Arthritis	○ Cerebral Palsy	○ Hearing Problems	○ Lung disorders
○ Asthma	○ Cold sores/oral ulcers	○ Heart disorders	○ Nervous disorders
○ AIDS/HIV	○ Diabetes	○ Heart murmur	○ Pneumonia
○ Bleeding disorders	○ Endocrine disorders	○ Hepatitis	○ Rheumatic fever
○ Bone disorders	○ Epilepsy	○ High blood pressure	○ Tuberculosis

○ Other ~ please specify: ____

Does the patient have a tendency to: ○ Colds ○ Sore throats ○ Ear infections

Any allergies or drug sensitivities? ○ Yes ○ No If yes, please explain: ____________________________________

Please list any medications presently taking: ____

GROWTH & DEVELOPMENT

Patient's height _______________________ Patient's weight ______________________________

Has the patient reached puberty?

Girls ~ Has she started menstruation? ○ Yes ○ No

Boys ~ Has his voice changed or is facial hair growth present? ○ Yes ○ No

Check one of the following which best describes his/her progress in school:

○ Behind children of the same age ○ Same level as children of the same age ○ Advanced beyond children of the same age

What is the patient's best subject in school? ____

Hobbies/ interests/ sports ____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize my dentist to release any information

Including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to third party payers and/or health practitioners. I agree to be responsible for payment of all services. I understand that, when necessary, credit information may be obtained.

X ____ Date: ______________________