

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ I prefer to be called \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_  
LAST FIRST MI  
Patient's SSN \_\_\_\_\_ Age \_\_\_\_\_ School Attending \_\_\_\_\_ Dentist \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_ Did you see our Website or Yellowpage add? (Circle)

**RESPONSIBLE PARTY INFORMATION**

Cell # \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_ DOB \_\_\_\_\_  
Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
LAST FIRST MI  
Mailing Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ How long at this address? \_\_\_\_\_  
STREET CITY STATE ZIP  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of Years Employed \_\_\_\_\_  
Other Parent/Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
LAST FIRST MI  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. of Years Employed \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Work Phone \_\_\_\_\_

**ORTHODONTIC INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's SSN \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Group No. \_\_\_\_\_ Insured's Employer \_\_\_\_\_ If you have dual coverage, please list your  
other Insurance Company \_\_\_\_\_ Secondary Insured's Name \_\_\_\_\_  
Secondary Insured's SSN \_\_\_\_\_ Employer \_\_\_\_\_ Group No. \_\_\_\_\_

**MEDICAL/DENTAL HISTORY**

Family History of (Circle All that apply) Underbite Overbite Neither Adopted?  Yes  No  
**Girls under 18:** Has she started menstruation?  Yes  No **Boys under 18:** Has his voice changed?  Yes  No  
Names and ages of Patient's Brothers \_\_\_\_\_ Sisters \_\_\_\_\_  
Family members previously in orthodontic treatment \_\_\_\_\_  
Any major or unusual illnesses or other health problems?  Yes  No Explain \_\_\_\_\_  
Currently under physician's care?  Yes  No Reason \_\_\_\_\_  
Allergies? (Check those that apply) Aspirin \_\_\_\_\_ Nickel \_\_\_\_\_ Latex \_\_\_\_\_ Other \_\_\_\_\_  
Drug sensitivity? Codeine \_\_\_\_\_ Penicillin \_\_\_\_\_ Erythromycin \_\_\_\_\_ Other \_\_\_\_\_  
Has the patient ever taken premedication for a dental procedure due to a heart condition? \_\_\_\_\_  
Please check if Patient Has or Had Any of the Following:  

Yes	No	Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	Hepatitis	Heart Valve replacement	Jaundice (Besides at birth)				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	Tuberculosis	Rheumatic fever	Epilepsy				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding	Diabetes	Malignancies, Tumors, or Cancer	Bone Disorders				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV positive	Asthma	Tonsils Removed: Age: _____	Endocrine Problems				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	Mitral valve prolapsed with regurgitation	Adenoids Removed: Age: _____	Emotional Stress				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

  Has the patient had any severe head or face injuries? Explain \_\_\_\_\_  
  Has the patient ever had a finger/thumb sucking habit? Is the habit still present?  Yes  No. Age habit stopped \_\_\_\_\_  
  Does the patient play any musical instruments that involve the mouth? What? \_\_\_\_\_  
  Has the patient consulted an orthodontist previously? Date \_\_\_\_\_ Doctor \_\_\_\_\_  
  Has the patient had any previous orthodontic treatment? Explain? \_\_\_\_\_

**PLEASE CHECK YES OR NO FOR THE FOLLOWING QUESTIONS**

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clenching Teeth	High Decay Rate	Jaw Joint Popping/Clicking			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grinding Teeth	Headaches (more than normal)	Ringing in the Ears			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Soreness (head & neck)	Jaw Joint Soreness	Tongue Thrust			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring Loudly	Mouth Breather	Speech Problem/Speech Therapy			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

When was the patient's last visit with their dentist? \_\_\_\_\_  
What do you or your dentist consider to be your main orthodontic problem? \_\_\_\_\_

I hereby agree that all the above information is both accurate and current. I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parents signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

