Date _____ **Confidential Patient Information**

Patient's Name _____
Last First Middle

Address _____ E-mail _____
Street City State Zip

Social Security _____ Date of Birth _____ Home Phone _____

If patient is a minor, give parent's or guardian's name _____ Cell Phone _____

Patient's Dentist _____ Dentist Phone: _____
First Last

Date of Last Visit _____ Whom may we thank for referring you to our office? _____

Have we treated any other family members in our office? _____ Names _____

Confidential Responsible Party Information

Name _____ Relationship to Patient _____
Last First Middle

Mailing Address _____
Street City State Zip

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security # _____ Date of Birth _____

Employer _____ Occupation _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Address _____
Street City State Zip

Work Phone _____ Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Social Security # _____ Date of Birth _____

Insurance Information

Policy Holder's Name _____ Date of Birth _____ Soc. Sec. # _____

Policy Holder's Address _____
Street City State Zip

Work Phone _____ Home Phone _____ Cell Phone _____

Insurance Company _____ ID / Member No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____ Group # _____

Do you have dual coverage? No ❑ Yes ❑ If yes:

Policy Holder's Name _____ Date of Birth _____ Soc. Sec. # _____

Policy Holder's Address _____
Street City State Zip

Work Phone _____ Home Phone _____ Cell Phone _____

Insurance Company _____ ID / Member No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____ Group # _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

Signature (responsible party's signature if minor) _____

Updates (date & initial) _____

Medical Information

Is the patient under care of a physician for a specific condition or taking any drugs? Please List: Drugs _____

_____

Has patient ever been under the care of a physician during the past two years? Yes ❑ No ❑

Please List: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

Diabetes . . . . . ❑	HIV/AIDS. . . . . ❑	Epilepsy . . . . . ❑	Endocrine Problems . . ❑
Pneumonia . . . . . ❑	Hepatitis . . . . . ❑	Asthma . . . . . ❑	Prolonged Bleeding . . . ❑
Heart Trouble . . . . . ❑	Tuberculosis . . . . . ❑	Kidney Involvement . . ❑	Fainting or Dizziness . . ❑
Rheumatic Fever . . . . ❑	Anemia . . . . . ❑	Emotional Problems . . ❑	Nervous Disorders . . . ❑
Bone Disorders. . . . . ❑	Hyperactive. . . . . ❑	Cerebral Palsy. . . . . ❑	Liver Involvement . . . . ❑

List any other serious illnesses and operations not mentioned above _____

List any allergies or drug sensitivity _____

Has the patient had any allergic reactions to latex? Yes ❑ No ❑

Have Tonsils and Adenoids been removed? Yes ❑ No ❑ (If so, what age? _____)

Dental History

YES	NO	
❑	❑	Has patient ever sucked thumb or finger? Until what age? _____
❑	❑	Does the patient breathe predominately through the mouth?
❑	❑	Does the patient clench or grind the teeth (at night)?
❑	❑	Does the patient have pain or clicking during jaw movement?
❑	❑	Have you been informed of missing permanent teeth?
❑	❑	Have you been informed of any extra teeth?
❑	❑	Have you had any previous orthodontic consultation or treatment?
❑	❑	Is patient adopted? At what age? _____
❑	❑	Has either parent had orthodontic treatment?

Chief Concern or Comments

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