

PATIENT INFORMATION

WELCOME TO OUR OFFICE!

Date

Patient’s Name

#### Last First Middle

Address

#### Street City State Zip

Home Phone Birth Date Social Security #

If patient is minor, give parent or guardian’s name

Patient: Responsible Party:

Email Address Email Address

# RESPONSIBLE PARTY INFORMATION

Name

Last First Middle Marital Status

Residence

#### Street City State Zip

Mailing Address

#### Street City State Zip

How long at this address Home Phone Work Phone

Previous Address (if less than 3 years)

##### Street City State Zip

Social Security # Birth Date Relationship to Patient

Employer Occupation No. Years Employed

Spouse’s Name Relationship to Patient

#### Last First Middle

Spouse’s Employer Occupation No. Years Employed

Spouse’s Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## INSURANCE INFORMATION

Insured’s Name DOB Insured’s Soc. Sec. #

Insurance Company Group # Local No.

Insurance Co. Address

Do you have dual coverage? Yes  No  If Yes, please continue:

Insured’s Name DOB Insured’s Soc. Sec. # Insurance Company Group # Local No.

Insurance Co. Address

Insured’s Employer

# EMERGENCY INFORMATION

Name of nearest relative not living with you

Complete Address

Phone Relationship to Patient

Signature (Parent’s signature, if minor) Date

I understand that where appropriate, credit bureau reports may be obtained.



HEALTH HISTORY

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever been evaluated or had orthodontic treatment before? | Yes | No |
| Have you ever had a serious/difficult problem associated with dental work? | Yes | No |
| Do you like your smile? | Yes | No |
| Have you ever had an injury to your Mouth/Teeth/Chin? | Yes | No |
| Do you have any speech problems? | Yes | No |
| Do you generally breathe through your mouth? | Yes | No |
| Do you floss your teeth daily? | Yes | No |
| Do you have any missing or extra permanent teeth? | Yes | No |
| Do you smoke or use tobacco in any form? | Yes | No |
| Have you experienced any discomfort in your jaw joint (TMJ/TMD)? | Yes | No |
| Have you ever taken or are taking Bisphosphonate medications? | Yes | No |
| Are you currently taking or have taken birth control medications? | Yes | No |
| Are you currently nursing or are you pregnant? | Yes | No |

Have you ever had any of the following medical problems?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Y | N | Abnormal Bleeding |  | Y | N | Hepatitis |
| Y | N | Anemia |  | Y | N | High/Low Blood Pressure |
| Y | N | Artifical Bones/Joints/Valves |  | Y | N | HIV+/AIDS |
| Y | N | Blood Transfusion |  | Y | N | Hospitalized for Any Reason |
| Y | N | Cancer/Chemotherapy |  | Y | N | Kidney Problems |
| Y | N | Congenital Heart Defect |  | Y | N | Mitral Valve Prolapse |
| Y | N | Diabetes |  | Y | N | Psychiatric Problems |
| Y | N | Difficulty Breathing |  | Y | N | Radiation Treatment |
| Y | N | Drug/Alcohol Abuse |  | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Emphysema |  | Y | N | Severe/Frequent Headaches |
| Y | N | Epilepsy/Seizures/Fainting |  | Y | N | Shingles |
| Y | N | Fever Blisters/Herpes |  | Y | N | Sickle Cell Disease/Traits |
| Y | N | Glaucoma |  | Y | N | Sinus Problems |
| Y | N | Heart Attack/Stroke |  | Y | N | Tuberculosis (TB) |
| Y | N | Heart Murmur |  | Y | N | Ulcers/Colitis |
| Y | N | Heart Surgery/Pacemaker |  | Y | N | Venerial Disease |

Are you allergic to any of the following?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Y | N | Aspirin |  | Y | N | Dental Anesthetics |
| Y | N | Penicillin |  | Y | N | Any Metals/Plastics |
| Y | N | Erythromycin |  | Y | N | Tetracycline |
| Y | N | Codeine |  | Y | N | Latex |
| Y | N | Food |  | Y | N | Drug |

Are you currently under Doctor Supervision for any physical/psychological conditions?

(IF YES PLEASE INCLUDE DIAGNOSIS & CURRENT TREATMENT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Name & Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

Patient Name: Date

Signature (Parent’s signature, if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_