



Date _____

Confidential Responsible Party Information

A B C

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Cell Phone _____ Work Phone _____

Previous Address (if less than 3yrs.) _____
Street City State Zip

Email Address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

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

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Confidential Patient Information

Patient's Name _____
Last First Middle Nickname

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ School _____ Social Security# _____

If patient is a minor, give parent's or guardian's name _____
 Whom may we thank for referring you to our office? _____
 Does the patient want orthodontic treatment? _____
 What does the patient wish to gain by orthodontic treatment? _____

Insurance Information

Policy Holder's Name _____ and Social Security # _____

Insurance Company Name _____ Group No. _____ Union Local No. _____

Insurance Company Address: _____ Insurance Co. Phone: _____

Policy Holder's Employer _____

Do you have dual coverage? No Yes

Policy Holder's Name _____ and Social Security # _____

Insurance Company Name _____ Group No. _____ Union Local No. _____

Insurance Company Address: _____ Insurance Co. Phone: _____

Policy Holder's Employer _____

Emergency Information

Name of Nearest Relative not living with you _____
 Complete Address _____
 Phone _____ Relationship _____

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

Signature (Parent's signature if minor) _____
 Update (date & initial) _____

FAMILY HISTORY

Names and ages of other children in the family _____
Is the patient adopted or by a second marriage? _____ Yes _____ No
Has anyone in the family had orthodontic treatment? _____ Yes _____ No

The answers to the next questions are needed to determine the growth potential left in your child which would help in orthodontic treatment.

Patient: Birth weight _____ Height now _____ Weight now _____
Mother: Weight _____ Height _____
Father: Weight _____ Height _____

Female Patients Only

Has menstruation begun? _____ Age when menstruation began? _____ Has growth spurt begun? _____
Menstrual cycle occurs approximately every _____ days.

Male Patients Only

Has growth spurt begun? _____ Has voiced changed? _____ Shoe size _____

PATIENT'S MEDICAL HISTORY

CIRCLE (All questions pertain to patient's medical history)

YES NO Is the patient in good health? Date of last check-up by physician: _____
YES NO Is the patient currently taking any drugs or medication? If yes, please list: _____

YES NO Is the patient allergic to any medication or substances? If yes, please list: _____

YES NO Is the patient pregnant? If yes, due date: _____
YES NO Does the patient have a medical condition that requires antibiotic pre-medication for dental procedures? If yes, please list medication prescribed: _____
YES NO Does the patient use any form of tobacco?
YES NO Does the patient have blood clotting problems?
YES NO Does the patient have any non-medication allergies (EX: metal or latex)? _____
YES NO Has the patient ever had Rheumatic fever or heart disease?
YES NO Have the patient's tonsils been removed?
YES NO Have the patient's adenoids been removed?
YES NO Does the patient have any problems breathing?
YES NO Has the patient had any surgical operations? If yes, please list: _____
YES NO Has the patient had previous orthodontic consultation? If yes, with whom? _____

Circle any of the following which the patient has had or has at present time

Lip or nail biting	Stomach ulcers	Chemotherapy	Hepatitis
Thumb habit until what age ___	Emphysema	Heart pacemaker	Allergies
Speech problems	Arthritis	Epilepsy or seizures	Diabetes
Mouthbreather	Heart problems	Injuries to face, mouth or teeth	Heart surgery
Missing teeth or extra teeth	Fainting or dizziness	High blood pressure	Stroke
Pain in ears __right__ left	AIDS or HIV infection	Psychiatric treatment	Birth defects
X-ray treatment	Cancer		

Other major illness: _____

Comments on anything you circled above or information you wish to add: _____

DENTAL HISTORY

To assist us in understanding your dental condition and experiences, please answer the following questions. If you have any doubts about the information requested, please ask the doctor.

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING TREATMENT:

- 1. Orthodontic (straightening of your teeth).....YES NO
As a child or adult happy or unhappy with result.
- 2. Extractions.....YES NO
How long ago _____ Reason for extraction _____
- 3. Periodontal treatment (gum treatment) YES NO
How long ago _____ Describe treatment _____
- 4. Mouthguard or splint (plastic device between your teeth) YES NO
- 5. Treatment or surgery to change your bite YES NO

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

- 6. Sore, lumps or irritated areas in your mouth YES NO
- 7. Food catching or collecting between your teeth YES NO
- 8. Clenching or grinding your teeth YES NO
- 9. Clicking, popping or grating noise in your jaw when chewing YES NO
Does it bother you? _____
- 10. Numbness or tingling in your mouth or face YES NO

- 11. Over the past five years how often have you been seen for teeth cleanings? _____
- 12. The date of your last visit to a dentist _____ That dentist's name _____
- 13. Are you frightened or anxious about dental or orthodontic treatment? YES NO
- 14. Have you had an unpleasant experience at the dental office? YES NO
Would you be willing to tell us about it so we avoid a similar experience? YES NO
Describe experience _____
- 15. What one aspect of orthodontic treatment/care are you most concerned with?
Quality Cost Discomfort Time

At times we may need to call you to discuss your care with you. If we cannot reach you directly, may we leave a message on your answering machine / voicemail? YES NO

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient Signature if over 18 years of age otherwise parent / guardian signature

Date