

**patient information**

**patient's name:** \_\_\_\_\_ **d.o.b.:** \_\_\_\_\_ **age:** \_\_\_\_\_ **sex:** \_\_\_\_\_  
(first) (middle) (last)

**ss#:** \_\_\_\_\_ **address:** \_\_\_\_\_  
(not necessary if patient is a child) (street) (city) (state) (zip)

**phone:** \_\_\_\_\_ **email:** \_\_\_\_\_ **school:** \_\_\_\_\_ **grade:** \_\_\_\_\_

**dentist:** \_\_\_\_\_ **I was referred to your office by:** \_\_\_\_\_

**family or friends seen in our office:** \_\_\_\_\_

**responsible party information**

**responsible party name:** \_\_\_\_\_ **d.o.b.:** \_\_\_\_\_

**ss#:** \_\_\_\_\_ **phone (h):** \_\_\_\_\_ **phone(w):** \_\_\_\_\_

**address:** \_\_\_\_\_ **how long at this address:** \_\_\_\_\_  
(street) (city) (state) (zip)

**previous address:** \_\_\_\_\_  
if less than 3 yrs ago (street) (city) (state) (zip)

**employer:** \_\_\_\_\_ **how long:** \_\_\_\_\_ **occupation:** \_\_\_\_\_

**other parent's name:** \_\_\_\_\_ **parents' marital status:** \_\_\_\_\_

**family information**

**with whom does the patient live** (custodial parent?) \_\_\_\_\_

**who should receive routine information about treatment progress?** \_\_\_\_\_

**who should receive financial information?** \_\_\_\_\_

**other adults we should know: name(s):** \_\_\_\_\_ **relationship to patient:** \_\_\_\_\_

**phone (h):** \_\_\_\_\_ **phone(w):** \_\_\_\_\_

**insurance information**

(fill out this section if your dental insurance provides orthodontic benefits)

**insured's name:** \_\_\_\_\_ **ss#:** \_\_\_\_\_ **d.o.b.:** \_\_\_\_\_  
(first) (middle) (last)

**insurance company:** \_\_\_\_\_ **group #:** \_\_\_\_\_ **policy #:** \_\_\_\_\_

**insurance co. address:** \_\_\_\_\_  
(street) (city) (state) (zip)

**insurance co. phone #:** \_\_\_\_\_ **insured's employer:** \_\_\_\_\_

**do you have dual insurance? yes**  **no**  **if yes:**

**insured's name:** \_\_\_\_\_ **ss#:** \_\_\_\_\_ **d.o.b.:** \_\_\_\_\_  
(first) (middle) (last)

**ins. co.:** \_\_\_\_\_ **Member ID #:** \_\_\_\_\_ **group #:** \_\_\_\_\_ **policy #:** \_\_\_\_\_

**insured's employer:** \_\_\_\_\_

**ins. co. address:** \_\_\_\_\_ **ins. co. phone #:** \_\_\_\_\_  
(street) (city) (state) (zip)

**dental and medical history**

patient's name: \_\_\_\_\_

**is the patient currently under the care of a physician? yes  no**

if yes, for what reason? \_\_\_\_\_

**physician's name** \_\_\_\_\_ **phone #** \_\_\_\_\_

**is the patient seeing any other dental specialists (e.g, periodontist)? yes  no**

if yes, for what reason? \_\_\_\_\_

**history of major illness? yes  no**  if yes, please describe: \_\_\_\_\_

**any sensitivities or allergies? yes  no**  if yes, please list: \_\_\_\_\_

**currently taking any medications? yes  no**

if yes, please list (including dosage): \_\_\_\_\_

**has the patient been treated for any of the following?**

<b>arthritis</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>epilepsy</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>asthma</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>heart condition</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>blood disorder</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>nervous disorder</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>cancer</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>tuberculosis</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>diabetes</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>osteoporosis</b>	yes <input type="checkbox"/> no <input type="checkbox"/>

**Are you currently undergoing or considering starting bisphosphonate treatment (e.g., Fosamax)? yes  no**

if yes, explain: \_\_\_\_\_

**does the patient require antibiotics before dental treatment? yes  no**

if yes, explain: \_\_\_\_\_

**have there been injuries to the patient's face, mouth or chin? yes  no**

**has the patient ever had pain/tenderness in the jaw joint (TMJ/TMD)? yes  no**

**is the patient a child?** if yes, please answer the following:

**has puberty begun? yes  no**

**has menstration (period) begun? yes  no  not applicable**

**have the adenoids or tonsils been removed? yes  no**

**have you been informed of any missing or extra permanent teeth? yes  no**

**does the patient have any or ever had any of the following habits?**

<b>cheek, tongue, or lip chewing</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>clenching teeth</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>finger nail biting</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>tongue thrusting</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>thumb sucking</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>grinding teeth</b>	yes <input type="checkbox"/> no <input type="checkbox"/>
<b>mouth breathing</b>	yes <input type="checkbox"/> no <input type="checkbox"/>	<b>speech problems</b>	yes <input type="checkbox"/> no <input type="checkbox"/>

**has the patient been examined by an orthodontist before? yes  no**

if yes, when? \_\_\_\_\_

**have other members of the family had orthodontics treatment? yes  no**

**if yes, were you happy with the results? yes  no**  if no, why? \_\_\_\_\_

**in your own words, what is the orthodontic problem?** \_\_\_\_\_

**I understand the information given is correct and will be held in strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.**

signature (legal guardian's signature if patient is a minor) \_\_\_\_\_

date \_\_\_\_\_