

**patient information****patient's name:** \_\_\_\_\_ **date** \_\_\_\_\_  
(first) (mi) (last)**birth date:** \_\_\_\_\_ **age:** \_\_\_\_\_ **sex:** \_\_\_\_\_ **ss#:** \_\_\_\_\_  
(not necessary if patient is a child)**address:** \_\_\_\_\_  
(street) (city) (state) (zip)**phone:** \_\_\_\_\_ **email:** \_\_\_\_\_**school:** \_\_\_\_\_ **grade:** \_\_\_\_\_**dentist:** \_\_\_\_\_ **i was referred to your office by:** \_\_\_\_\_**other family or friends seen in our office:** \_\_\_\_\_**responsible party information****responsible party's name:** \_\_\_\_\_  
(first) (mi) (last)**address:** \_\_\_\_\_  
(street) (city) (state) (zip)**how long at this address:** \_\_\_\_\_ **(h) phone:** \_\_\_\_\_ **(w) phone:** \_\_\_\_\_**previous address:** \_\_\_\_\_  
if less than 3 yrs ago (street) (city) (state) (zip)**birth date:** \_\_\_\_\_ **ss#:** \_\_\_\_\_ **relationship to patient:** \_\_\_\_\_**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 about:

name: \_\_\_\_\_ relationship to patient: \_\_\_\_\_

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

## insurance information

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

insured's name: \_\_\_\_\_ ss#: \_\_\_\_\_  
(first) (mi) (last)

insured's d.o.b.: \_\_\_\_\_ insurance company: \_\_\_\_\_

group #: \_\_\_\_\_ policy #: \_\_\_\_\_

insurance co. address: \_\_\_\_\_

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

do you have dual insurance? \_\_\_\_\_

if yes:

insured's name: \_\_\_\_\_ ss#: \_\_\_\_\_  
(first) (mi) (last)

insured's d.o.b.: \_\_\_\_\_ insurance company: \_\_\_\_\_

group #: \_\_\_\_\_ policy #: \_\_\_\_\_

insurance co. address: \_\_\_\_\_

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

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

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

\_\_\_\_\_  
date

### dental and medical history

is the patient currently under the care of a physician?

yes  no  if yes, for what reason? \_\_\_\_\_

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

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 (include dosage): \_\_\_\_\_

has the patient been treated for any of the following?

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

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 menstruation (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 or ever had any of the following habits?

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

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

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

have other members of the family had orthodontic 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 the strictest confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

signature (parent's signature if patient is a minor)

date

please complete other side of this form. . .