

Welcome to Our Office!

CONFIDENTIAL PATIENT INFORMATION

Patient's Name _____ Sex M F
Last First MI
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ School _____
If patient is a minor, give parent's or guardian's name _____
Whom may we thank for referring you to our office? _____ General Dentist: _____

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status _____
Last First MI
Residence _____ Own Rent
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address? _____ Home Phone _____ Work Phone _____ Cell _____
Previous Address (if less than 3 yrs.) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to patient _____
Employer _____ Occupation/Military Rank _____ No. Years Employed _____
Responsible Party's Email Address _____
Spouse's Name _____ Relationship to patient _____
Last First MI
Employer _____ Occupation/Military Rank _____ No. Years Employed _____
Social Security # _____ Birthdate _____ Work Phone _____ Cell _____

DENTAL INSURANCE *(Please provide Dental Insurance Card upon visit.)*

Policy Holder's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Address _____ Phone _____
Policy Holder's Employer _____
Do you have dual Coverage? Yes No If YES:
Policy Holder's _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Address _____ Phone _____
Policy Holder's Employer _____

IN CASE OF AN EMERGENCY, please provide the name of nearest relative not living with you:

Name _____ Relationship to Patient _____
Home _____ Work _____ Cell _____

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

Signature *(Parent or Guardian's signature if minor)* _____ Date _____



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Patient's Name _____

MEDICAL HISTORY

MEDICAL RELEASE

	YES	NO
Does the patient have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient sensitive to any drug or medication?	<input type="checkbox"/>	<input type="checkbox"/>
If so, what drug(s)? _____		
Has the patient ever had heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had any serious illnesses or condition requiring a physician's care or hospitalization?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please explain _____		

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

Diabetes	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Liver Involvement	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Kidney Involvement	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>
Bone Disorders	<input type="checkbox"/>	Emotional Problems	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>
Hyper Activity	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	Herpes Simplex	<input type="checkbox"/>
				AIDS or HIV infection	<input type="checkbox"/>

Physician _____

List any drugs or medications now being taken. Give reasons: _____

DENTAL HISTORY

Yes No

Has patient ever sucked thumb or fingers?
Until what age? _____

Does the patient breathe predominantly through the mouth?

Does the patient have any speech problems?

Does the patient clench or grind teeth (at night)?

Does the patient have pain or clicking upon closing the mouth?

Has the patient had any severe head or face injuries?

Have any teeth been chipped due to accidents?

Have you been informed of missing permanent teeth?

Yes No

Have you been informed of any extra teeth?

Were any teeth (baby or permanent) removed by extraction?

Was it suggested that the space be maintained?

Was an appliance placed to maintain the space?

Have you ever had any previous orthodontic consultation or treatment?

Is the patient adopted?

Does anyone in family have similar dental condition?

Would patient mind wearing "braces"?

Any noticeable difficulty in chewing or swallowing food?

Have x-rays of teeth been taken? Yes No If YES, when? _____ Full Mouth? Yes No

By whom? _____