Welcome to Our Office!

PATIENT INFORMATION

Patient's Name _____ Sex ☐ M ☐ F
Last First MI

Address _____
Street City State Zip

Cell 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? _____

Which method(s) would you prefer to receive notifications of your future appointments? *Check all that apply*

☐ Email _____ ☐ Text Messaging_____ ☐ None

RESPONSIBLE PARTY INFORMATION *(Person financially responsible for making payment)*

Name _____ Marital Status _____
Last First MI

Residence _____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? ___ Cell Phone_____ Work Phone_____ Home Phone _____

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 _____

How would you prefer to receive your statements? ☐ Email ☐ Mail

Spouse's Name _____ Relationship to patient _____
Last First MI

Social Security # _____ Birthdate _____ Email _____

Employer _____ Occupation/Military Rank_____ No. Years Employed _____

Spouse's Email Address _____ Home 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. _____

Do you have dual Coverage? Yes ☐ No ☐ If YES:_____

Policy Holder's_____ Insured's Soc. Sec. #_____

Insurance Company_____ Group No._____ Local No._____

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 rating may be obtained.

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

Patient's Name

_____

MEDICAL/DENTAL HISTORY

Physician's Name:_____Phone_____

Dentist's Name:_____Phone_____

☐ Yes ☐No Is patient adopted?

☐ Yes ☐No Are you currently under any medical treatment?_____

☐ Yes ☐No When was the date of your last dental cleaning?_____

☐ Yes ☐No Do you have pain, clicking, and/or popping noises in the jaw?_____

☐ Yes ☐No Are you aware of either clenching or grinding of teeth?_____

☐ Yes ☐No Do you have frequent headaches? How often?_____

☐ Yes ☐No Do you have ear problems? (Aches, ringing, dizziness, fullness)_____

☐ Yes ☐No Do you have difficulty breathing through the nose?_____

☐ Yes ☐No Do you have habits such as nail biting, finger or thumbsucking, lip or cheek biting?_____

☐ Yes ☐No Do you have speech problems, or are you in speech therapy?_____

☐ Yes ☐No Have you had your tonsils and/or adenoids removed?_____

☐ Yes ☐No Has there been any history of: ☐Joint swelling ☐Asthma ☐TB ☐Aids ☐Kidney ☐Liver Condition ☐Epilepsy ☐Rheumatic fever ☐Other major illnesses?_____

☐ Yes ☐No Do you bleed easily?_____

☐ Yes ☐No Is there a tendency to faint or become dizzy?_____

☐ Yes ☐No Do you have allergies? (Sulphur, penicillin, novocaine, etc.)_____

☐ Yes ☐No Are you currently taking any medication? List:_____

☐ Yes ☐No Do you have a heart condition? ☐Yes ☐No

Do you pre-medicate? ☐Yes ☐No If yes,

cardiologist:_____

☐ Yes ☐No Do you have sleep apnea?_____

☐ Yes ☐No Do you smoke or chew tobacco?_____

☐ Yes ☐No Have there been any injuries to the teeth?_____

☐ Yes ☐No Have you had any permanent teeth extracted?_____

☐ Yes ☐No Have we treated any other family members? ☐Yes ☐No Who?_____

_____

YIM Orthodontics