PATIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____/_____/_____AGE_____
(Last) (First) (MI)
MALE:_____ FEMALE:_____ SOCIAL SECURITY :_____-_____-_____ DRIVERS LICENSE:_____

Single:_____ Married:_____ Divorced:_____ Separated:_____ Widowed:_____ OTHER FAMILY MEMEBERS SEEN BY US:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME TELEPHONE: (____)_____ WORK Telephone(____)_____ CELL PHONE: (____)_____

EMPLOYER_____ OCCUPATION:_____

EMPLOYER ADDRESS_____

DENTIST:_____ WHOM MAY WE THANK FOR YOUR REFERRAL:_____
EMAIL ADDRESS:_____

INSURANCE

PRIMARY INSURANCE INFORMATION

Please circle the following:
ORTHODONTIC COVERAGE? Yes No DENTAL? Yes No

Insured's Name:_____ Insured's Birthdate:_____

Insured's Social Security #: _____

Ins. Co. Phone:_____ Group or Policy #:_____

Ins. Co. Name:_____

Ins. Co. Address:_____

Employer:_____

SECONDARY INSURANCE INFORMATION

Please circle the following:
ORTHODONTIC COVERAGE? Yes No DENTAL? Yes No

Insured's Name:_____ Insured's Birthdate:_____

Insured's Social Security #: _____

Ins. Co. Phone:_____ Group or Policy #:_____

Ins. Co. Name:_____

Ins. Co. Address:_____

Employer: _____

DENTAL

What is your primary concern for an orthodontic evaluation?_____

Has you ever had or been evaluated for orthodontic treatment? Yes _____ No _____ If yes, please explain:_____

Is pre-medication required prior to dental procedures (SBE prophylaxis): Yes _____ No_____

Any pain / discomfort in jaw joint (TMJ /TMD)? Yes ____ No ____

History of the following Lip Biting ____ Nail Biting ____ Thumb/Finger Sucking____

Current dental health is? Good _____ Fair _____ Poor _____

Speech problems? Yes _____ No_____

Do you still have wisdom teeth? Yes _____ No_____

Has there been any injury to: Mouth _____ Teeth _____ Chin_____

Are you aware of missing or extra permanent teeth? Yes _____ No _____

Do you generally breath through your mouth? Yes_____ No_____

Are you happy with the way your smile looks? Yes _____ No_____

If not, what would you like to see changed?_____

MEDICAL INFORMATION

Are you currently under the care of a physician? Yes_____ No _____ If so please explain:_____

Physicians Name_____ Physicians Phone:_____

Are you taking any prescription / over the counter medications: Yes_____ No_____ If so please list:_____

Current Physical Health: Good _____ Fair _____ Poor _____

Do you smoke or use tobacco: Yes _____ No _____

CHECK ANY OF THE FOLLOWING DISEASES OR MEDICAL CONDITIONS THAT MAY APPLY:

___ Abnormal Bleeding	___ Difficulty Breathing	____ Herpes / Fever Blisters	____ Seizures
___ AIDS	___ Emphysema	____ High Blood Pressure	____ Shingles
___ Alcohol / Drug Abuse	___ Epilepsy	____ HIV	____ Sickle Cell Disease / Traits
___ Anemia	___ Fainting Spells	____ Hospitalized for Any Reason	____ Sinus Problems
___ Arthritis	___ Frequent Headaches	____ Kidney Problems	____ Stroke
___ Artificial Bones / Joints	___ Glaucoma	____ Liver Disease	____ Thyroid Problems
___ Blood Transfusion	___ Hay Fever	____ Low Blood Pressure	____ Tuberculosis (TB)
___ Cancer / Chemotherapy	___ Heart Attack / Surgery	____ Mitral Valve Prolapse	____ Ulcers
___ Colitis	___ Heart Murmur	____ Pacemaker	____ Venereal Disease
___ Congenital Heart Defect	___ Hemophilia	____ Psychiatric Problems	
___ Diabetes	___ Hepatitis	____ Rheumatic / Scarlet Fever	

Please list any serious medical conditions:_____

Are you aware of any allergies to any of the following? Aspirin ____ Codeine ____ Dental Anesthetics ____ Erythromycin ____ Jewelry / Metal ____
____ Latex ___ Penicillin ____ Tetracycline ____ Other Please explain:_____

RELEASE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in financial or medical status. I authorize the dental staff to perform any necessary dental services needed during diagnosis and treatment, with my informed consent. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover and authorize payment of the group insurance benefits (otherwise payable to me) directly to this office. This office reserves the right to verify the credit status of potential patients and or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____ _____
Signature **Date**