PATIENT

NAME:_____ DATE OF BIRTH:_____/_____/_____ MALE:_____ FEMALE:_____
(Last) (First) (MI)

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

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

OTHER FAMILY MEMBERS SEEN BY US:_____ SIBLINGS:_____ Ages:_____

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

PARENT

FATHER'S NAME:_____ OCUPATION: _____

EMPLOYER:_____ BUSINESS PHONE:_____

MOTHER'S NAME:_____ OCUPATION:_____

EMPLOYER:_____ BUSINESS PHONE::_____

Person Financially Responsible for Account:_____ RELATION TO PATIENT:_____

Single:___ Married:___ Divorced:___ Separated:___ Widowed:___

IF DIFFERENT FROM PATIENT

ADDRESS:_____ HOME PHONE:_____

EMIAL 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:_____

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:_____

DENTAL

What is your primary concern for an orthodontic evaluation?_____

PLEASE CHECK THE FOLLOWING INFORMATION THAT APPLIES TO PATIENT

Has patient 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_____

Does patient 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 _____

Are you happy with the way patient's teeth look? Yes _____ No_____ If not, what would you like to see changed?_____

MEDICAL INFORMATION

Is patient under the care of a physician? Yes_____ No _____ If so please explain:_____

Physicians Name_____ Physicians Phone:_____

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

Patient's Current Physical Health: Good _____ Fair _____ Poor _____

Have tonsils and adenoids been removed: Yes _____ No _____

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

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

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:_____

REALEASE

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