ORTHODONTICS, INC

Please complete the following information. Please print. This information is necessary for our files and will be considered confidential.

ID#

PATIENT INFORMATION

Email address _____

Date: ____/____/____ Have we seen other members of your family? ☐ Yes ☐ No

Name: _____

Patient's Name _____
Last First Middle

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Birthdate _____ Social Security # ____-____-____

☐ Female ☐ Male If patient is a minor, give parent or guardian name: _____
Name-Relationship

Whom may we thank for referring you to our office? _____

Dentist Name _____ Last Cleaning Visit ____/____/____
Name

RESPONSIBLE PARTY INFORMATION

Name _____
Last First MI Marital Status/Relationship to Patient

Residence _____
Street City State Zip Home Phone

Mailing Address _____
Street City State Zip

Birthdate ____/____/____ Social Security # ____-____-____ Driver's License # _____ State

Employer _____
Name Street City State Zip Phone

Spouse Name _____
Last First MI Relationship to Patient

Employer _____
Name Street City State Zip Phone

Birthdate ____/____/____ Social Security # ____-____-____ Driver's License # _____

INSURANCE INFORMATION

Name of Insured _____
Last First MI Birthdate/Social Security Number

Primary Insurance _____
Name Street City State Zip Phone

Name of Insured _____
Last First MI Birthdate/Social Security Number

Secondary Insurance _____
Name Street City State Zip Phone

EMERGENCY INFORMATION

Name _____
Last First MI Relationship to Patient

Address _____
Street City State Zip Home Phone

PLEASE COMPLETE REVERSE SIDE

ORTHODONTICS, INC

DENTAL HISTORY

Why have you come to the Orthodontist today?_____

_____

Your current dental health is: Good Fair Poor
Are you currently in pain? Yes No
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Yes No
Do you like your smile? Yes No
Do your gums ever bleed? Yes No
How many times a week do you floss?_____
How many times a week do you brush?_____
Type of bristles? Hard Medium Soft

FOR WOMEN ONLY

Are you pregnant? Yes No
Are you nursing? Yes No

FOR CHILDREN ONLY

Thumb sucking/Finger sucking Yes No
Tongue Thrusting Yes No
Lip Sucking/Biting Yes No
Nail Biting Yes No
Nursing Bottle Habits Yes No
Mouth Breathing Yes No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Aspirin	Y N	Erythromycin	Y N
Codeine	Y N	Dental Anesthetics	Y N
Latex	Y N	Penicillin	Y N

Other:_____

MEDICAL HISTORY

Do you have a personal physician? Yes No

_____
Name Phone

Your current physical health is? Good Fair Poor
Are you currently under the care of a physician? Yes No
If yes, explain:_____
Are you taking any prescription drugs? Yes No
If yes, list:_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Prosthesis	Y N	Hearing Impairment	Y N
Heart Attack	Y N	Congenital Heart Def.	Y N
Cancer	Y N	Radiation Treatment	Y N
Diabetes	Y N	Abnormal Bleeding	Y N
Rheum. Fever	Y N	Artificial Implants (teeth)	Y N
HIV+/AIDS	Y N	Hepatitis	Y N
Any Stays in Hospital	Y N	For:_____	
Asthma	Y N	Nervous Problems	Y N
Hemophilia	Y N	Kidney/Liver Problems	Y N
Tuberculosis	Y N	Chronic Ear Problems	Y N
Herpes	Y N	Chronic Sinus Problems	Y N
Fever Blister	Y N	High/Low Blood Press	Y N
Anemia	Y N	Drug/Alcohol Abuse	Y N
Ulcers/Colitis	Y N	Blood Transfusion	Y N
Heart Murmur	Y N	Convulsions/Epilepsy	Y N
Glaucoma	Y N	Heart Surgery/Pacemaker	Y N
Cerebral Palsy	Y N	Difficulty Breathing	Y N
Shingles	Y N	Handicaps/Disabilities	Y N
Severe/Freq.Headaches	Y N		
Tonsils Removed	Y N		

Other:_____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the doctor.

_____ _____ _____
Signature of patient/parent/guardian **Relationship** **Date**

OFFICE USE ONLY---OFFICE USE ONLY---OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.
Initials_____ **Date**_____ **Doctor's comments:**_____

_____

Medical History Update:
Date_____ **Initials**_____ **Comments**_____
Date_____ **Initials**_____ **Comments**_____