

**PATIENT INFORMATION**

Patient's Last Name:				Patients' First Name		Patient Prefers to be Called		Gender M/F	
Patient's DOB			Patient's Age		Patient's E-Mail Address			Patient's Social Security #	
Patient Street Address				Patient's City, ST Zip		Patient's Home Ph #		Patient's Cell #	
<b>If patient is a minor, give parent's or guardian's name:</b> _____									
<b>Whom may we thank for referring you to our office?</b> _____									

**Are other family members treated here? Yes No** If so, who?:

**Sibling/Children information:**

<u>1.</u>		-		<u>3.</u>		-		
Sibling/Child Full Name		M/F	Sibling/Child DOB		Sibling/Child Full Name		M/F	Sibling/Child DOB
<u>2.</u>		-		<u>4.</u>		-		
Sibling/Child Full Name		M/F	Sibling/Child DOB		Sibling/Child Full Name		M/F	Sibling/Child DOB

**RESPONSIBLE PARTY INFORMATION**

Resp Party Last Name:		Resp Party First Name		Resp Party Email Address		Relationship to patient	
<b>Marital Status: Single Married Divorced Widowed Separated</b>							
Resp. Party Street Address			Resp. Party City, ST Zip		Resp. Party Home Ph #	Resp. Party Work Ph #	Resp. Party Cell Ph #
<b>How long at this address:</b> _____							
Resp. Party Social Security #		Resp. Party Employer		Resp. Party Occupation		# Yrs Current Employer	Resp. Party DOB
<b>Previous Address if less than 3 yrs at current residence:</b>							
Previous Address			Previous City, ST Zip		Resp Party email address		

**Spouse/Partner Information:**

Spouse/Partner		Relationship to Patient		Occupation		# Yrs Current Employer	Spouse/Partner DOB
Spouse/Partner Social Security #		Spouse/Partner Work Ph #		Spouse/Partner Cell Ph#		Spouse/Partner Email Address	

**PRIMARY DENTAL INSURANCE INFORMATION**

Insured's Last Name:		Insured's First Name		Insured's Soc. Sec. #		Insurance Co Name		Insured's Group #	
Insurance Co St Address			Insurance Co. City, ST Zip		Insurance Co Ph #		Insureds' Employer	Insured's DOB	
<b>Do you have dual insurance coverage? Yes No</b>					<b>Do you have a pre-tax flexible spending account?: Yes No</b>				

**EMERGENCY INFORMATION – RELATIVE OR FRIEND NOT LIVING WITH YOU**

Emergency contact name		St Address			City, ST Zip	
Relationship	Emergency contact's home Ph#		Emergency contact's work Ph#		Emergency contact's cell Ph#	

**PATIENT INFORMATION**

Patient's Dentist	Last Dental Visit
<b>Orthodontic</b>	<b>Dental</b>
<b>Medical</b>	
<b>Has an orthodontist been previously consulted?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>What was your dentist's main concern?</b>
<b>Physician's Name:</b>  <b>Last physical exam:</b> -      - <b>Hospitalizations?</b>	<b>Is _____ under the care of a physician at this time?</b> <input type="checkbox"/> yes <input type="checkbox"/> no  <b>If yes, please explain reason for physician's care:</b>
<b>In your own words, describe your orthodontic problems and what would you like orthodontics to accomplish?</b>	<b>Is there any dental work that needs to be completed prior to orthodontic treatment?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>Indicate the patient's feelings toward orthodontic treatment?</b> <input type="checkbox"/> eager to get started <input type="checkbox"/> complacent <input type="checkbox"/> not committed to cooperate	<b>Are antibiotics necessary for teeth cleanings?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
<b>Hobbies/Comments:</b>	<b>What was the date of your last cleaning?</b>
	<b>List any medications being taken at this time:</b>  <b>Are you currently or have you taken bisphosphonates?</b> <input type="checkbox"/> yes <input type="checkbox"/> no
	<b>List any drugs/things that _____ is allergic to or has a reaction to:</b>

**Please complete \_\_\_\_\_ medical history information. Please check yes or no if you have or have had:**

Abnormal Adenoids/Tonsils <input type="checkbox"/> yes <input type="checkbox"/> no	Endocrine problems <input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis/Osteopenia <input type="checkbox"/> yes <input type="checkbox"/> no
AIDS/HIV <input type="checkbox"/> yes <input type="checkbox"/> no	Epilepsy <input type="checkbox"/> yes <input type="checkbox"/> no	Prolonged bleeding <input type="checkbox"/> yes <input type="checkbox"/> no
Allergies <input type="checkbox"/> yes <input type="checkbox"/> no	Faintness/Dizziness <input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric treatment <input type="checkbox"/> yes <input type="checkbox"/> no
Arthritis <input type="checkbox"/> yes <input type="checkbox"/> no	Fever blisters <input type="checkbox"/> yes <input type="checkbox"/> no	Rad/Chemo/Blood therapy <input type="checkbox"/> yes <input type="checkbox"/> no
Artificial heart valves <input type="checkbox"/> yes <input type="checkbox"/> no	Headaches (frequent) <input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory Problems <input type="checkbox"/> yes <input type="checkbox"/> no
Asthma <input type="checkbox"/> yes <input type="checkbox"/> no	Heart murmur <input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic/Scarlet/Yellow fever <input type="checkbox"/> yes <input type="checkbox"/> no
Bone disorders <input type="checkbox"/> yes <input type="checkbox"/> no	Heart trouble <input type="checkbox"/> yes <input type="checkbox"/> no	Scoliosis <input type="checkbox"/> yes <input type="checkbox"/> no
Blood disease <input type="checkbox"/> yes <input type="checkbox"/> no	Finger/Thumb/Lip Sucking <input type="checkbox"/> yes <input type="checkbox"/> no	Shortness of breath <input type="checkbox"/> yes <input type="checkbox"/> no
Cancer <input type="checkbox"/> yes <input type="checkbox"/> no	Hemophiliac <input type="checkbox"/> yes <input type="checkbox"/> no	Sinus Trouble <input type="checkbox"/> yes <input type="checkbox"/> no
Cardiac pacemaker <input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis <input type="checkbox"/> yes <input type="checkbox"/> no	Stroke <input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart lesions <input type="checkbox"/> yes <input type="checkbox"/> no	Herpes <input type="checkbox"/> yes <input type="checkbox"/> no	TMJ problems <input type="checkbox"/> yes <input type="checkbox"/> no
Chronic cough <input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice <input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid problems <input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes <input type="checkbox"/> yes <input type="checkbox"/> no	Joint swelling <input type="checkbox"/> yes <input type="checkbox"/> no	Tonsils removed <input type="checkbox"/> yes <input type="checkbox"/> no
Drug addiction <input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease <input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis <input type="checkbox"/> yes <input type="checkbox"/> no
Ear Problems <input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease <input type="checkbox"/> yes <input type="checkbox"/> no	Artificial bones/joints <input type="checkbox"/> yes <input type="checkbox"/> no
Emotional problems <input type="checkbox"/> yes <input type="checkbox"/> no	Organ transplant <input type="checkbox"/> yes <input type="checkbox"/> no	Wound healing problems <input type="checkbox"/> yes <input type="checkbox"/> no
	Muscle or joint disorder <input type="checkbox"/> yes <input type="checkbox"/> no	Whiplash <input type="checkbox"/> yes <input type="checkbox"/> no

  

Is the patient pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Is bite uncomfortable? <input type="checkbox"/> yes <input type="checkbox"/> no	Cheek, tongue or lip chewing? <input type="checkbox"/> yes <input type="checkbox"/> no
Has patient reached puberty? <input type="checkbox"/> yes <input type="checkbox"/> no	Severe frequent headaches? <input type="checkbox"/> yes <input type="checkbox"/> no	Clenching teeth? <input type="checkbox"/> yes <input type="checkbox"/> no
Any facial injuries? <input type="checkbox"/> yes <input type="checkbox"/> no	Trauma to the jaw? <input type="checkbox"/> yes <input type="checkbox"/> no	Grinding teeth? <input type="checkbox"/> yes <input type="checkbox"/> no
Mouth breathing? <input type="checkbox"/> yes <input type="checkbox"/> no	Does the patient smoke? <input type="checkbox"/> yes <input type="checkbox"/> no	Fingernail habit? <input type="checkbox"/> yes <input type="checkbox"/> no
Missing/extra permanent teeth? <input type="checkbox"/> yes <input type="checkbox"/> no	Abnormal height or weight? <input type="checkbox"/> yes <input type="checkbox"/> no	Drink energy drinks regularly? <input type="checkbox"/> yes <input type="checkbox"/> no
Speech problems? <input type="checkbox"/> yes <input type="checkbox"/> no	Adopted? Does he/she know? <input type="checkbox"/> yes <input type="checkbox"/> no	
Pain or clicking on opening mouth? <input type="checkbox"/> yes <input type="checkbox"/> no	Latex allergy? <input type="checkbox"/> yes <input type="checkbox"/> no	

**Please explain ANY Disease, Medical or Dental Condition that is not mentioned above:**

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CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I understand that where appropriate; credit bureau reports may be obtained.

Signature (Parent's signature if minor)	Date
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Updates- Date	Initial	Updates- Date	Initial
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