



DATE: \_\_\_\_\_

# WELCOME

Our mission is to provide the highest quality orthodontic care in a fun and caring environment.

Please fill out both sides of this form.

## PATIENT INFORMATION

Name: \_\_\_\_\_  
LAST FIRST M

Birthday \_\_\_/\_\_\_/\_\_\_ Age \_\_\_ Sex \_\_\_\_\_

Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Wk#: \_\_\_\_\_ Ext: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen by us? \_\_\_\_\_

Dentist: \_\_\_\_\_ Last cleaning: \_\_\_\_\_

Previous orthodontist: \_\_\_\_\_

Orthodontic concerns: \_\_\_\_\_

## SPOUSE INFORMATION

His/Her name: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Wk#: \_\_\_\_\_ Ext: \_\_\_\_\_

Responsible party: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_

## MEDICAL HISTORY

Physician's name: \_\_\_\_\_ # \_\_\_\_\_

Are you currently under the care of a physician? If so please explain:  
\_\_\_\_\_

List any medications being taken and reason: \_\_\_\_\_

List any drugs/materials that you are allergic to:  
\_\_\_\_\_

Have you had tonsils and/or adenoids removed? If yes, what age \_\_\_\_\_

Have you ever had any of the following medical problems/procedures?

- |     |                       |     |                         |
|-----|-----------------------|-----|-------------------------|
| Y N | Abnormal bleeding     | Y N | Hepatitis               |
| Y N | Anemia                | Y N | Herpes/fever blisters   |
| Y N | Alcohol/drug abuse    | Y N | High blood pressure     |
| Y N | Arthritis             | Y N | HIV+/AIDS               |
| Y N | Artificial bones etc. | Y N | Prev. hospitalization   |
| Y N | Asthma                | Y N | Kidney/liver prob.      |
| Y N | Blood transfusion     | Y N | Low blood pressure      |
| Y N | Bone disorder         | Y N | Mononucleosis           |
| Y N | Cancer/chemotherapy   | Y N | Nervous disorder        |
| Y N | Colitis               | Y N | Pneumonia               |
| Y N | Diabetes              | Y N | Psychiatric problems    |
| Y N | Difficulty breathing  | Y N | Radiation               |
| Y N | Emphysema             | Y N | Rheumatic/scarlet fever |
| Y N | Endocrine problems    | Y N | Seizures                |
| Y N | Epilepsy              | Y N | Shingles                |
| Y N | Fainting or dizziness | Y N | Sickle cell             |
| Y N | Frequent headaches    | Y N | Sinus problems          |
| Y N | Glaucoma              | Y N | Skin rash               |
| Y N | Hay fever             | Y N | STD's                   |
| Y N | Hearing impairment    | Y N | Stroke                  |
| Y N | Heart trouble         | Y N | Thyroid problems        |
| Y N | Hemophilia            | Y N | Tuberculosis            |
|     |                       | Y N | Ulcers                  |

Other illness or operations: \_\_\_\_\_

## EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you we should contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Hm #: \_\_\_\_\_ Wk#: \_\_\_\_\_

## DENTAL HISTORY

Any injuries to the face, mouth, or teeth? Yes No

\_\_\_\_\_

History of thumb or finger habit? Yes No

Until what age? \_\_\_\_\_

Does the patient have speech problems? Yes No

Describe \_\_\_\_\_

Is the patient a mouth breather? Yes No

While awake? Yes No

While asleep? Yes No

Missing or extra permanent teeth Yes No

\_\_\_\_\_

Have you previously consulted an orthodontist? Yes No

Previous orthodontic treatment? Yes No

Has either parent had orthodontic treatment? Yes No

Do you require antibiotics prior to dental appts. Yes No

Do you now or have you ever experienced pain/  
discomfort in you jaw joint (TMJ/TMD)? Yes No

Grinding or clenching habit? Yes No

Cheek biting? Yes No

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 it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

\_\_\_\_\_  
Signature Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

## INSURANCE INFORMATION

### PRIMARY INSURANCE

Patient name: \_\_\_\_\_

Subscribers name: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ Group#: \_\_\_\_\_

Birthdate of subscriber: \_\_\_\_\_

### SECONDARY INSURANCE

Subscribers name: \_\_\_\_\_

Subscribers SS#: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #: \_\_\_\_\_ Group#: \_\_\_\_\_

Birthdate of subscriber: \_\_\_\_\_

I understand that I am responsible for payment for services rendered and also responsible for paying any copayment and deductions that my insurance does not cover.

\_\_\_\_\_  
Signature Date

### Doctor's comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY UPDATE

1. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_  
2. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_  
3. Date: \_\_\_\_\_ Comments \_\_\_\_\_ Signature: \_\_\_\_\_