Today's date:_____

Name:_____
Last First MI Mr Mrs Ms Dr
I prefer to be called:_____
Birthdate:____/____/____ Age:_____ Male ___ Female ___
Home Address_____
_____
City State Zip
Single__ Married __ Divorced __ Widowed__ Separated __
Hm#: ( )_____ Pager/Other#: ( )_____
Wk#: ( )_____ Ext:_____ DL#:_____
E-mail Address: _____
Employer:_____
Employer's address:_____
How long there?_____ Occupation:_____
When & where are the best times to reach you?_____
Whom may we thank for referring you?_____
Other family members seen by us:_____
General Dentist:_____
Last visit date:_____

Spouse Information

His / Her Name:_____
Employer: _____
Wk#: ( )_____ Ext:_____ SS #: _____
Birthdate: ____/____/____

Person responsible for Account:_____
Wk #: ( )_____ Ext:_____ Hm #:_____
Relation:_____ SS#_____
Employer:_____ DL#: _____

Orthodontic Insurance - Primary Orthodontic coverage __ yes __ no Insurance Co.
Name:_____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, local or policy #): _____
Relationship to Patient: _____
Policy's Owner's Birthdate: __/____/____ SS #: _____
Policy Owner's Employer: _____

Orthodontic Insurance - Secondary Orthodontic coverage ___yes ___ no
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: _____
Group # (Plan, local or policy #): _____
Relationship to Patient: _____
Policy Owner's Birthdate: ___/____/____ SS #: _____
Policy Owner's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?
His/ Her Name:_____ Relation:_____

Wk#: (____)_____ Hm #: (_____)_____

Medical History

Do you have a personal physician? ___ yes ___no
Physician's Name: _____
Phone #: (____)_____ Date of last visit: _____
Your current physical health is: ___ good ___ fair ___poor
Are you currently under the care of a physician? ___yes ___no
Please explain: _____
Are you taking any prescription / over-the-counter drugs?
Please list each one:_____
For Women: Are you taking birth control pills? ____yes ____no
Are you pregnant? ___ yes ___no Week #: _____
Are you nursing? ____ yes ___no

Have you ever had any of the following diseases or medical problems?

_Y _ N Anemia / Radiation Treatment
_ Y _ N Artificial Bones / Joints
_ Y _ N Artificial Valves
_ Y _ N Asthma / Arthritis
_ Y _ N Blood Transfusion
_ Y _ N Cancer / Chemotherapy
_ Y _ N Congenital Heart Defect
_ Y _ N Diabetes / Tuberculosis
_ Y _ N Difficulty Breathing
_ Y _ N Drug / Alcohol Abuse
_ Y _ N Emphysema / Glaucoma
_ Y _ N Epilepsy / Seizures / Fainting Spells
_ Y _ N Fever Blisters / Herpes
_ Y _ N Heart Attack / Stroke
_ Y _ N Heart Murmur
_ Y _ N Heart Surgery / Pacemaker
_ Y _ N Hemophilia / Abnormal Bleeding
_ Y _ N Hepatitis
_ Y _ N High / Low Blood Pressure
_ Y _ N HIV+ / AIDS
_ Y _ N Hospitalized for any reason
_ Y _ N Kidney Problems
_ Y _ N Mitral Valve Prolapse
_ Y _ N Psychiatric Problems
_ Y _ N Rheumatic / Scarlet Fever
_ Y _ N Severe / Frequent Headaches
_ Y _ N Shingles
_ Y _ N Sinus Problems
_ Y _ N Ulcers / Colitis
_ Y _ N Venereal Disease

Please list any serious medical conditions(s) that you have ever had: _____
_____

Are you allergic to any of the following?
_ Y _ N Aspirin
_ Y _ N Any Metal / Plastic
_ Y _ N Codeine
_ Y _ N Other
_ Y _ N Dental anesthetics
_ Y _ N Erythromycin
_ Y _ N Latex

Please list any other drugs that you are allergic to:_____
_____

Dental History

What are the main concerns that you would like orthodontics to accomplish? _____

_____
_____

Have you ever had or been evaluated for orthodontic treatment? __Y __ N
Have you ever had a serious / difficult problem associated with any previous dental work? _ Y _N

Do you now or have you ever experienced pain / discomfort
in your jaw joint (TMJ / TMD __Y __N
Your current dental health is: __ Good __ Fair __ Poor
Do you like your smile? __ Y __ N Do your gums ever bleed __Y __ N
Have you ever had an injury to your: __ Mouth __ Teeth __ Chin
Do you have any speech problems? _____
_____

Do you generally breathe through your mouth? __ Y __ N Awake? __ Y __ N Asleep?
Do you have any missing or extra permanent teeth? __ Y __ N

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

Thank you for filling out this form completely.

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

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

_____
Office Use Only -- Office Use Only -- Office Use Only -- Office Use Only -- Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein.

_____
Initials Date

Doctor's Comments: _____
_____
_____