



Date: \_\_\_\_\_

**Patient Information**

Patients Name: \_\_\_\_\_  
Last First Middle (Nickname)

Address: \_\_\_\_\_  
Street City Zip

Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

If patient is a minor, Parent/Guardian: \_\_\_\_\_ School \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_ Siblings/Children's Ages: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

**Responsible Party Information/Custodial Parent (MUST BE COMPLETED)**

Name: \_\_\_\_\_  
Last First Middle

Residence: \_\_\_\_\_  
Street City Zip Circle one: Rent or Own

Mailing Address: \_\_\_\_\_  
Street City Zip

How long at this address: \_\_\_\_\_ Daytime/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Previous Address (if less than 3 yrs): \_\_\_\_\_ Email Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ No. Years Employed: \_\_\_\_\_

SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Orthodontic Insurance Information**

Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Ins Co: \_\_\_\_\_ Ins Co. Address \_\_\_\_\_

Group #: \_\_\_\_\_ Local # \_\_\_\_\_ Ph # \_\_\_\_\_

Secondary Ins. Insured's Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Ins Co: \_\_\_\_\_ Ins Co Address \_\_\_\_\_

Group #: \_\_\_\_\_ Local # \_\_\_\_\_ Ph # \_\_\_\_\_

### Medical History

Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Yes No** Are you taking any medication? \_\_\_\_\_ **Yes No** Are you allergic to any medication? \_\_\_\_\_

**Yes No** Are you allergic to latex, metals, or jewelry? \_\_\_\_\_ **Yes No** Do you have a history of a major illness? \_\_\_\_\_

**Yes No** Have you ever or are you now taking bisphosphonates such as Boniva, Fosamax or Actonel? \_\_\_\_\_

**Yes No** Are you pregnant? \_\_\_\_\_ **Circle any of the medical conditions below that you have had or currently have:**

Abnormal Bleeding/Hemophilia	Bone Disorders	Gastrointestinal Disorders	Low/High Blood Pressure	Pneumonia
Anemia	Diabetes	Heart Problems/Murmur	HIV/AIDS	Radiation/Chemotherapy
Arthritis	Dizziness/Fainting	Hepatitis/Liver Problems	Kidney Problems	Rheumatic Fever
Asthma/HayFever	Epilepsy	Herpes/Venereal Disease	Nervous Disorders	Tuberculosis
				Tumor/Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

### Dental History

General Dentist: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_ What concerns you most about your teeth? \_\_\_\_\_

**Yes /No** Are you presently in any dental pain? \_\_\_\_\_

**Yes/No** Have you ever lost or chipped any teeth? \_\_\_\_\_

**Yes/No** Are you a mouth breather? \_\_\_\_\_

**Yes/No** Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_

**Yes/No** Do you have any type of thumb or tongue habit? \_\_\_\_\_

**Yes/No** Are you aware of clenching your teeth during the day? \_\_\_\_\_

**Yes/No** Have you ever been told that you grind your teeth? \_\_\_\_\_

**Yes/No** Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_

**Yes/No** Are you aware of your jaw clicking or popping? \_\_\_\_\_

**Yes/No** Do your gums bleed when you brush? \_\_\_\_\_

**Yes /No** Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_

**Yes /No** Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_

**Yes/No** Have you or has anyone in your family ever seen an orthodontist? If so, who and when? \_\_\_\_\_

### Emergency Information

Name of the nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. I do \_\_\_\_\_ do not \_\_\_\_\_ authorize any other person to receive medical/dental/financial information. Other person authorized to obtain information \_\_\_\_\_.

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