



Please take a few minutes to fill out this necessary information that will enable us to better serve you. We will be happy to assist you with any questions you may have.

PATIENT INFORMATION:

Today's date: _____

Patient's Name: _____

Last

First

Middle

Nickname: _____ SSN: _____

Birth date: _____ Age: _____ Male: _____ Female: _____

Home Address: _____

Home Phone #: (_____) _____ Patient lives with: _____

Interests/Hobbies: _____

School: _____ Grade: _____

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

Why are you currently seeking treatment? What would you like orthodontic treatment to accomplish? _____

FAMILY INFORMATION:

Mother's Name: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address (if different from above): _____

Father's Name: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address (if different from above): _____

Marital Status: _____

Other Children in Family (Names & ages): _____

Email Address: _____

Who is responsible for making appointments? _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact: _____

Name

Relation to patient

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation to patient: _____

Billing Address (if different from above): _____

Employer: _____ Phone #: _____

SSN: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

INSURANCE:

Primary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#/SSN: _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#/SSN _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

MEDICAL HISTORY:

Physician's Name: _____ Last Visit: _____ Phone #: _____

Address: _____

Is patient currently under the care of a physician? If yes, please explain: _____

Is patient taking any medications? Y/N If so, list: _____

Has patient ever been hospitalized? If yes, please explain: _____

Is patient allergic to the following?

Local Anesthesia	Y/N	Latex	Y/N	Penicillin/Other Antibiotics	Y/N
Metals	Y/N	Sulfa Drugs	Y/N	Plastics	Y/N
		Aspirin	Y/N	Iodine	Y/N

Other Allergies: _____

Has patient ever had any of the following diseases or medical problems?

Abnormal/ Prolonged bleeding	Y/N	Congenital Heart Defect	Y/N	Kidney Problems	Y/N
ADHD	Y/N	Diabetes	Y/N	Neurologic Disorders	Y/N
Anemia	Y/N	Drug/Alcohol Abuse	Y/N	Osteoporosis	Y/N
Angina/ Chest pain	Y/N	Epilepsy/Seizures	Y/N	Pyschiatric Disorders	Y/N
Artificial joints/valves	Y/N	Fever Blisters/Herpes	Y/N	Rheumatic/Scarlet Fever	Y/N
Arthritis	Y/N	Glaucoma	Y/N	Severe/Frequent Headaches	Y/N
Asthma	Y/N	Heart Disease	Y/N	Shortness of Breath	Y/N
Birth Defects	Y/N	Heart Murmur	Y/N	Sinus Problems	Y/N
Bone Disorders	Y/N	Hepatitis	Y/N	Surgeries	Y/N
Blood transfusions	Y/N	High/Low Blood Pressure	Y/N	Thyroid/Parathyroid Disorders	Y/N
Cancer/Chemotherapy/Radiation	Y/N	HIV+/AIDS	Y/N	Tuberculosis	Y/N

Please list any serious past or current medical problems: _____

Female patients: Has patient reached menstruation/puberty? Y/N

