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 #

If patient is a minor, give parent's or guardian's name: _____

Whom may we thank for referring you to our office?

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

Sibling/Children information:

1. Sibling/Child Full Name | M/F | Sibling/Child DOB
3. Sibling/Child Full Name | M/F | Sibling/Child DOB
2. Sibling/Child Full Name | M/F | Sibling/Child DOB
4. Sibling/Child Full Name | M/F | Sibling/Child DOB

RESPONSIBLE PARTY INFORMATION

Last Name: | First Name | Email Address | Relationship to patient

Marital Status: Single Married Divorced Widowed Separated

Street Address | City, ST Zip | Home Ph # | Work Ph # | Cell Ph #

SPOUSE/PARTNER Information:

Name | Relationship to Patient | Occupation | # Yrs Current Employer | DOB

Social Security # | Work Ph # | Cell Ph# | Email Address

WORK INFORMATION

Employer Name | Occupation | # Yrs Current Employer | Work Phone#

Address | City, | ST | Zip

SPOUSE/PARTNER Work Information: (IF FINANCING)

Name | Relationship to Patient | Occupation | # Yrs Current Employer | DOB

Social Security # | Work Ph # | Cell Ph# | Email Address

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Last Name: | Insured's First Name | Insured's Soc. Sec. # | Insurance Co Name | Insured's ID #

Insurance Co St Address | Insurance Co. City, ST Zip | Insurance Co Ph # | Insureds' Employer | Insured's DOB

Do you have dual insurance coverage? Yes No **Do you have a pre-tax flexible spending account?: Yes No**

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's name	Patient's Dentist	Last Dental Visit

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

Please complete PATIENT'S medical history information. Please check yes or no if you have or have had:

Abnormal Adenoids/Tonsils	☐ yes ☐ no	ADD/ADHD/Hyperactivity	☐ yes ☐ no	Hepatitis	☐ yes ☐ no
Adenoids/Tonsils removed	☐ yes ☐ no	Emotional problems	☐ yes ☐ no	Abnormal height or weight	☐ yes ☐ no
AIDS/HIV+	☐ yes ☐ no	Drug/Alcohol abuse	☐ yes ☐ no	LATEX ALLERGY	☐ yes ☐ no
Asthma	☐ yes ☐ no	Fever blisters/Herpes	☐ yes ☐ no	Does the patient smoke?	☐ yes ☐ no
Epilepsy/Convulsions	☐ yes ☐ no	Has patient reached puberty?	☐ yes ☐ no	Injuries to face/mouth/teeth	☐ yes ☐ no
Arthritis	☐ yes ☐ no	Is the patient pregnant?	☐ yes ☐ no	Headaches/Migraines	☐ yes ☐ no
Artificial joints/valves	☐ yes ☐ no	Headaches (severe/frequent)	☐ yes ☐ no	Whiplash	☐ yes ☐ no
Heart Murmur	☐ yes ☐ no	Any hospital stays	☐ yes ☐ no	TMJ problems	☐ yes ☐ no
Congenital heart defect	☐ yes ☐ no	Any operations	☐ yes ☐ no	Jaw joint noise/pain	☐ yes ☐ no
Heart problems of any kind	☐ yes ☐ no	Bone disorders	☐ yes ☐ no	Jaw locked open	☐ yes ☐ no
Bleeding problems	☐ yes ☐ no	Difficulty breathing	☐ yes ☐ no	Mouth breathing habit	☐ yes ☐ no
Hemophilia	☐ yes ☐ no	High/Low Blood Pressure	☐ yes ☐ no	Tongue-thrust habit	☐ yes ☐ no
Rheumatic/Scarlet Fever	☐ yes ☐ no	Stroke/Heart attack	☐ yes ☐ no	Finger/Thumb/Lip Sucking	☐ yes ☐ no
Thyroid Problems	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no	Fingernail biting habit	☐ yes ☐ no
Hearing Impairment	☐ yes ☐ no	Faintness/Dizziness	☐ yes ☐ no	Tooth clenching/grinding habit	☐ yes ☐ no
Diabetes	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no	Cheek, tongue or lip chewing?	☐ yes ☐ no
Cancer	☐ yes ☐ no	Disabilities	☐ yes ☐ no	Speech problems	☐ yes ☐ no
Kidney/Liver problems	☐ yes ☐ no	Glaucoma	☐ yes ☐ no		

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

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

I Consent to the dental practice using my cell phone number to (choose one or both) ___call ___text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is:_____

Signature:_____ Initial:_____