



PATIENT INFORMATION

First: _____ Middle Initial: _____ Last: _____ Nickname: _____
 Birthdate: _____ Gender: _____ Email: _____
 Phone: _____ Cell/Alternate Phone: _____
 Address: _____ City/State: _____ Zip: _____
 List friends or relatives in the practice: _____
 How did you find out about our office? _____
 List any sports, hobbies, or musical instruments played: _____

FINANCIAL PARTY INFORMATION (IF INFORMATION IS DIFFERENT THAN PATIENT)

First: _____ Last: _____
 Phone: _____ Cell/Alternate Phone: _____
 Email: _____
 Address: _____ City/State: _____ Zip: _____
 Relationship to Patient: _____ Occupation: _____

PARENT/GUARDIAN INFORMATION (IF PATIENT IS UNDER 18)

Parent/Guardian Name: _____
 Parent/Guardian Name: _____
 Married Single Separated Divorced If separated or divorced, which parent does child live with? _____

Please list the name and birthdate of any siblings: _____

DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Address: _____ Phone: _____
 Subscriber's Name: _____ Subscriber's #/SS: _____ Birthdate: _____
 Subscriber's Employer: _____ Group #: _____ Phone: _____

DENTAL HISTORY

Patient's Dentist: _____ Phone: _____ Last Cleaning: _____
 Please describe your orthodontic concern: _____
 Has the patient had any previous orthodontic treatment? With whom? _____
 What concerns you most about the thought of orthodontic treatment? _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Speech problems/therapy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Discomfort from teeth or gums?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Grind or clench teeth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pain, tenderness, or noise in either jaw?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Oral habits (thumb/finger sucking, lip/nail biting)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent sore throats?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Injury to face, jaw, teeth, or mouth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Requires premedication?	<input type="checkbox"/> YES <input type="checkbox"/> NO



Brush teeth daily? YES NO
 Floss teeth daily? YES NO
 Flouride treatments? YES NO
 Mouth breathing? YES NO
 Snores during sleep? YES NO

Any missing or extra permanent teeth? YES NO
 Apprehensive about dental care? YES NO
 Frequently chews gum? YES NO
 Ringing in the ears? YES NO

If you answered YES to any of the questions above, please explain: _____

MEDICAL HISTORY

Patient's Physician: _____ Address: _____

Phone: _____ Is patient in good health? YES NO Date of last physical: _____

Please list any medications currently being taken by patient: _____

Have you taken any Bisphosphonates? YES NO If YES, when? _____

Please list any drug allergies/sensitivities patient may have: _____

Please select YES if the patient has had any of the conditions listed below either currently or in the past.

Rheumatic Fever	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tuberculosis/Lung Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Family History of Cancer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pneumonia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Received Radiation Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Growth Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Kidney Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Endocrine Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Attack/Stroke	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hormone Therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Disease	<input type="checkbox"/> YES <input type="checkbox"/> NO	Latex/Metal Allergy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Congenital Heart Defect	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nervous Disorders	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Murmur	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bone Disorders/Bone Loss	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hemophilia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hypertension/High Blood Pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures/Epilepsy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Prolonged Bleeding/Transfusion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Handicaps/Disabilities	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anemia	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO	Arthritis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Treated for Emotional Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tonsils/Adenoids Removed	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ever Been Hospitalized	<input type="checkbox"/> YES <input type="checkbox"/> NO

If you answered YES to any of the questions above, please explain: _____

If the patient is under the age of 18, please answer the following questions:

Height: _____ Weight: _____ School: _____ Grade: _____

If patient is a girl, has menstruation began? YES NO If so, when? _____

If patient is a boy, has their voice changed? YES NO

Has the patient grown in the past year or has their shoe size changed recently? YES NO

Is patient interested in orthodontic treatment? YES NO

Has either biological parent ever had orthodontic treatment? YES NO

Signature: _____ Date: _____