Patient Information

(PLEASE FILL OUT COMPLETELY)

Patient Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Cell: _____ Other Phone: _____ Email: _____

Primary Care Physician: _____General Dentist's Name: _____

General Dentist's Address: _____ Phone: _____

Names of Guardians: _____

Relationship to Patient: _____

Patient's Siblings Name / Age:_____ Referred by: _____

MEDICAL & DENTAL HISTORY

	YES	NO			YES	NO
Is the Patient in good health?	☐	☐	Reason: _____	Has the patient had any severe head or face injuries?	☐	☐
Any major or unusual illnesses?	☐	☐	Explain: _____	Has the patient consulted an orthodontist previously?	☐	☐
Currently under physician's care?	☐	☐	Reason: _____	Has the patient had any previous orthodontic treatment?	☐	☐
Currently taking medication?	☐	☐	List: _____	Is the patient fearful of having dental work done?	☐	☐
Any allergies?	☐	☐	List: _____	Has the patient ever had a bad dental experience?	☐	☐
Drug Sensitivity?	☐	☐	List: _____	Do you require premedication for dental work?	☐	☐
Have you ever been hospitalized?	☐	☐	If so, for what? _____	Why are you seeking orthodontic treatment? _____		

Please check if patient has or has had any of the following:

☐ Anemia	☐ Diabetes: Type: ____	☐ Rheumatic Fever	☐ Adenitis: Age Removed: _____
☐ Blood Disease	☐ Tuberculosis	☐ Herpes	☐ Tonsillitis: Age Removed: _____
☐ Prolonged Bleeding	☐ Endocrine Problems	☐ Frequent Colds or Flu	☐ Mouthbreathing while awake
☐ Hepatitis	☐ Bone Disorders	☐ Asthma	☐ Mouthbreathing while assleep
☐ Jaundice	☐ Epilepsy	☐ AIDS / HIV positive	☐ Jaundice
☐ Heart Disease	☐ Seizures	Are you in a risk group for AIDS/HIV? ☐ Yes ☐ No	

Please check if there is a history of:

☐ Clenching teeth	☐ Grinding teeth	☐ Jaw joint clicking	☐ Ringing in ears
☐ Jaw joint soreness	☐ Frequent headaches	☐ Jaw joint soreness	☐ Jaw joint locking ☐Open ☐Closed
☐ Muscular soreness around head or neck		☐ Thumb or finger sucking	

DENTAL INSURANCE INFORMATION

In order to process your insurance, this form must be filled out completely.

Primary Dental Insurance:

Card Holder's Name: _____

Card Holder's Address: (if different from above) _____

_____

Card Holder's date of birth: _____

Employer's Name: _____

Work Number: _____

Name of Dental Insurance Company: _____

Insurance Address: _____

City: _____State: _____Zip: _____

Insurance Phone #: _____

Member # / Identification # / Subscriber ID # / Social Security #:

_____

Policy / Group #: _____ Eff. Date: _____

Secondary Dental Insurance: *(if applicable)*

Card Holder's Name: _____

Card Holder's Address: (if different from above) _____

_____

Card Holder's date of birth: _____

Employer's Name: _____

Work Number: _____

Name of Dental Insurance Company: _____

Insurance Address: _____

City: _____State: _____Zip: _____

Insurance Phone #: _____

Member # / Identification # / Subscriber ID # / Social Security #:

_____

Policy / Group #: _____ Eff. Date: _____

I have given the above updated personal, dental, medical, and insurance information. To the best of my knowledge all information is found to be accurate. If there are any further changes to this history, I will inform your practice. I also give my authorization for orthodontic treatment to be performed.

Signature: _____ Date: _____