

Patient Information

Date _____ Nickname _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____ E-mail _____

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

Names of Relatives treated here _____ Relationship _____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Cell # _____ E-mail _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Birthdate _____ Relationship to Patient _____

Spouse's Employer _____ Work Phone _____ Cell # _____ SS # _____

Occupation _____ No. Years Employed _____ E-mail _____

List Additional Financially Responsible Party If Any

Name _____
Last First Middle

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Home Phone _____ Work Phone _____

Residence _____
Street City State Zip How Long

Mailing Address _____
Street City State Zip

Previous Address _____
Street City State Zip

Orthodontic Insurance Information

Insured's Name _____ Birthdate _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If Yes: Phone Number (____) _____

Insured's Name _____ Birthdate _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone Number (____) _____

I understand that appropriate credit reports may be obtained, and give permission for diagnostic records to be taken which may be used for educational or promotional materials. Our office respects your privacy and will provide you with our Notice of Privacy Practices upon request.

Signature (Parent's or guardian's signature if minor) _____ (OVER)

MEDICAL HISTORY

Physician's Name _____

Address _____

IS PATIENT IN GOOD HEALTH? _____ Yes No

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? _____ Yes No

HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? _____ Yes No

PLEASE LIST: _____

In case of emergency, contact _____

name / phone / relationship to patient

Check any of the following for which the patient has been treated:

Diabetes Anemia Prolonged Bleeding

Pneumonia Epilepsy Fainting or Dizziness

Heart Trouble Asthma Nervous Disorders

Rheumatic Fever Kidney Involvement Liver Involvement

Bone Disorders Tuberculosis Endocrine Problems

DOES PATIENT HAVE TENDENCY TO COLDS SORE THROATS EAR INFECTIONS

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ Yes No

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: _____

Any Additional Information: _____

Date of last cleaning/exam with family dentist _____

Primary orthodontic concern _____