

**Patient Information**

Name \_\_\_\_\_, \_\_\_\_\_ ( \_\_\_\_\_ ) Gender: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Last First Preferred Name month-day-year

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City Zip

Home Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Name of Parent/Guardian (if patient is a minor) \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Have you visited other orthodontists before? Yes \_\_\_ No \_\_\_

**Responsible Party Information**

Name \_\_\_\_\_, \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Last First

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City State Zip

Mailing Address (if different) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Phone: Home(\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Work(\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ #Years Employed \_\_\_\_\_

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City State Zip

Spouse (if applicable) Name \_\_\_\_\_, \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Last First

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ #Years Employed \_\_\_\_\_

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Street City State Zip

**Insurance Company Information**

Insured Name #1 \_\_\_\_\_ Insured Name #2 \_\_\_\_\_

Insurance Company \_\_\_\_\_ Insurance Company \_\_\_\_\_

Insurance Company Phone # \_\_\_\_\_ Insurance Company Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Insurance Company Address \_\_\_\_\_

\_\_\_\_\_

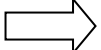
Insurance Group # \_\_\_\_\_ Insurance Group # \_\_\_\_\_

**We will assist you in filing insurance claims.** However, your insurance policy and coverage is an arrangement between your employer and the insurance company. Therefore, insurance checks will be mailed to you rather than to our office. If an insurance payment check is mailed to us, we will endorse it and return it to you.

You may also benefit from IRS approved programs that allow the use of pre-tax income to pay for healthcare. Does your employer offer the following health savings programs?

Flexible Spending Account (FSA) Yes \_\_\_ No \_\_\_

Health Savings Account (HSA) Yes \_\_\_ No \_\_\_

Continued  


## In Case of Emergency, Please Notify the Following

Name \_\_\_\_\_, \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Email \_\_\_\_\_@\_\_\_\_\_

Last First

Address \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Street City State Zip

Patient's Name \_\_\_\_\_, \_\_\_\_\_ (\_\_\_\_\_) Gender: \_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Last First Nickname month day year

Patient's Health Care Providers: Dentist: Dr. \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Primary Physician: Dr. \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

The following questions are about you, the patient. Please answer all questions.

Yes No

Yes No

Are you in good health?

Is there any major illness in the past?

Are you allergic to penicillin?

Are you allergic to nickel?

Please list any medical condition that your orthodontist should know before giving you treatment.

None

### Health Background

Have you ever had any of the following health problems? Please answer all questions (check Yes or No).

Yes No

Yes No

Yes No

Allergies/Sinus

Frequent colds

Speech problems

Anemia

Glaucoma

Surgery

Arthritis

Heart trouble

Tuberculosis

Asthma

Autism Spectrum

Hepatitis

Thyroid

Bleeding problems

Hyperactivity

Tumors

Bone disorders

Immune deficiency

Ulcers

Cold sores/HSV1

Kidney disease

Any serious medical problem

Concussion

Liver problems

Injuries to face, mouth, teeth

Diabetes

Psychiatric Treatment

Ever had tonsils removed

Epilepsy

Pneumonia

Ever had any cancer \_\_\_\_\_

Fainting/Dizziness

Rheumatic fever

Snoring

Sleep apnea

Taking any medication List: \_\_\_\_\_

### Dental Information

Yes No

Yes No

A thumb, finger or other sucking habit?

A habit of grinding or clenching teeth?

Mouth breathing?

Noise, pain, or locking of jaw joints?

Previous orthodontic examination?

Has any parent or sibling had braces?

Did teeth come in at the usual time?

Any missing or extra teeth?

Any injuries to the face, mouth, or teeth? If yes, please provide detail. \_\_\_\_\_

I certify that the information that I have given here and elsewhere to this office is complete and true to the best of my knowledge. I understand that this information will be held in strict confidence, and it is my responsibility to inform this office of any changes of the information provided (including the patient's medical status).

Signature of Patient (or Parent/Guardian if Patient is a minor)

Date

Print Name: \_\_\_\_\_

#### Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named. \_\_\_\_\_

Initial

Date