

## Patient Information

Patient's Name	_____	_____	_____	_____
	Last	First	Middle	
Address	_____	_____	_____	_____
	Street	City	State	Zip
Cell Phone	_____	Birthdate	Social Security #	_____
Email Address	_____	General Dentist	_____	_____

## Responsible Party Information

Name	_____	_____	_____	_____
	Last	First	Middle	Marital Status
Residence	_____	_____	_____	_____
	Street	City	State	Zip
Mailing Address	_____	_____	_____	_____
	Street	City	State	Zip
Cell Phone	_____	Work Phone	_____	Home Phone
Email Address	_____			
Social Security #	_____	Birthdate	_____	Relationship to Patient
Employer	_____	Occupation	_____	No. Years Employed
<b>Other Responsible Party Name</b>	_____	_____	_____	_____
	Last	First	Middle	Marital Status
Residence	_____	_____	_____	_____
	Street	City	State	Zip
Mailing Address	_____	_____	_____	_____
	Street	City	State	Zip
Cell Phone	_____	Work Phone	_____	Home Phone
Email Address	_____			
Social Security #	_____	Birthdate	_____	Relationship to Patient
Employer	_____	Occupation	_____	No. Years Employed

## DENTAL Insurance Information

Who is Insurance Policy Under (Self, Parent, Etc?)Name:	_____
Policy Holder's Birthdate	_____
Policy Holder's Soc. Sec. #	_____
Name of Insurance Company (ie: Blue Cross)	_____
Group No.	_____
Policy or Member ID# on Card:	_____
Employer (Job)	_____
Address of Policy Holder	_____
Insurance Co. Customer Service Phone # on Back of Card:	_____
Do you have dual coverage? Yes No	_____
If yes: Insured's Employer	_____
Insured's Name	_____
Birthdate	_____
Soc. Sec. #	_____
Insurance Company	_____
Group No.	_____
Insurance Co. Customer Service Phone #	_____



Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

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

Hobbies/Interests \_\_\_\_\_

YES NO **Medical History**

\_\_\_\_\_ Is patient presently under a physician's care?  
 For \_\_\_\_\_

\_\_\_\_\_ Is patient taking any pills, medications, or drugs? \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Has patient ever had an unusual reaction to medication? \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Is patient allergic to anything? \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Has patient had any major surgery? For \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Does patient have a chronic problem with  Kidney  Heart  Lung  Liver

\_\_\_\_\_ Are there any other medical problems not mentioned above? \_\_\_\_\_

Describe: \_\_\_\_\_

Has patient been diagnosed or treated for any of the following: (Circle)

- |               |                 |                 |                  |                    |        |
|---------------|-----------------|-----------------|------------------|--------------------|--------|
| Diabetes      | Arthritis       | Bone Recession  | Osteoporosis     | Epilepsy           | Anemia |
| Endocrine     | Asthma          | Fainting        | Cerebral palsy   | Prolonged bleeding |        |
| Heart trouble | Rheumatic fever | Tonsils removed | Adenoids removed |                    |        |

YES NO **Dental History**

\_\_\_\_\_ Does patient now suck thumb or fingers?  
 \_\_\_\_\_ Does patient breathe predominantly through the mouth?  
 \_\_\_\_\_ Does the patient clench or grind teeth?  at night  during day  
 \_\_\_\_\_ Does the patient have pain or clicking upon closing the mouth?  
 \_\_\_\_\_ Has the patient had any severe head or face injuries? When \_\_\_\_\_  
 \_\_\_\_\_ Have any teeth been injured or chipped due to accidents? When \_\_\_\_\_  
 \_\_\_\_\_ Any noticeable difficulty in chewing or swallowing food?  
 \_\_\_\_\_ Has patient been informed of any extra or missing teeth?  
 \_\_\_\_\_ Have any teeth (baby or permanent) been removed by extraction? Why \_\_\_\_\_  
 \_\_\_\_\_ Has any member of the family had orthodontic treatment? Who \_\_\_\_\_  
 \_\_\_\_\_ Have you had any previous orthodontic consultation or treatment?  
 \_\_\_\_\_ Would patient mind wearing  Bands?  Headgear?  
 \_\_\_\_\_ Has patient ever been teased about appearance of his/her teeth?  
 \_\_\_\_\_ Does the patient want his/her teeth straightened?  
 \_\_\_\_\_ Has a dentist ever placed a retainer or space maintainer? Month of last dental appointment \_\_\_\_\_