

Patient Information

Section 1

Today's Date: _____

Patient's Name: _____
Last First Middle

E-mail Address: _____ SS#: _____

Birthdate: ____/____/____ Age: _____ Gender: _____

Address: _____
Street City State Zip

Phone Numbers: Home _____ Mobile _____

Primary Dentist: _____ Phone Number: _____ Date of Last Visit: _____

Section 2 (If you are under 18 years of age, please fill out the following)

Father's Name: _____ Birthdate: ____/____/____

Work #: _____ Mobile #: _____

SS #: _____ - _____ - _____ (for insurance billing purposes only)

Employer: _____ Marital Status: _____

E-mail Address: _____

Mother's Name: _____ Birthdate: ____/____/____

Work #: _____ Mobile #: _____

SS #: _____ - _____ - _____ (for insurance billing purposes only)

Employer: _____ Marital Status: _____

E-mail Address: _____

Person Responsible for Account: _____

Section 3

Dental Insurance Co. Name: _____

Orthodontic Coverage? Yes _____ No _____ Not sure _____

Insurance Co. Phone #: _____

Group #: _____ Policy #: _____

Policy Holder: Name _____ DOB _____ SS# _____

Section 4

What would you like your orthodontist to accomplish for you?

Have you had an orthodontic examination or treatment before? Yes _____ No _____

Have there been any injuries to your face, mouth, or teeth? Yes _____ No _____

Have you had any TMJ (jaw joint) symptoms? Yes _____ No _____

Has **puberty** begun? Yes _____ No _____ If yes, when? _____

(For women) Are you **pregnant**? Yes _____ No _____ If yes, how many weeks? _____

Please list all names and dosage of **medication** you are currently taking:

Section 5

Have you ever had any of the following medical problems?

- | | | | |
|--------------------|----------------------------|--------------------|----------------------------|
| Yes _____ No _____ | Abnormal Bleeding | Yes _____ No _____ | Allergies to any Drugs |
| Yes _____ No _____ | Allergies to Latex / Metal | Yes _____ No _____ | Any Hospital Stays |
| Yes _____ No _____ | Any Operations | Yes _____ No _____ | Artificial Joints / Valves |
| Yes _____ No _____ | Asthma | Yes _____ No _____ | Cancer |
| Yes _____ No _____ | Congenital Heart Defect | Yes _____ No _____ | Convulsions / Epilepsy |
| Yes _____ No _____ | Diabetes | Yes _____ No _____ | Disabilities |
| Yes _____ No _____ | Heart Murmur | Yes _____ No _____ | Hepatitis |
| Yes _____ No _____ | HIV / AIDS | Yes _____ No _____ | Kidney Disease |
| Yes _____ No _____ | Rheumatic Fever | Yes _____ No _____ | Tuberculosis |

If yes to any of the above medical questions, please provide detailed information:
