



Jeff Stanley DDS, Inc.

tel (559) 435-6465

fax (559) 435-5504

6465 N. Palm Avenue

Suite 105

Fresno CA 93704



Member American Association of Orthodontists

Patient # _____

PATIENT INFORMATION

Date _____

| | | | | | |
|-----------|-------|----------|-----------|--------|------------------------------------|
| Last Name | First | Nickname | Birthdate | Age | M F <small>(circle one)</small> |
| Address | City | Zip Code | Telephone | School | |

Has any member of your family undergone orthodontic treatment? Yes No If yes, name _____

Do you know anyone being treated in this office? Yes No If yes, name _____

| | |
|--------------------------|--------------------------------------|
| PATIENT'S DENTIST | Whom may we thank for referring you? |
|--------------------------|--------------------------------------|

RESPONSIBLE PARTY INFORMATION

| | | | | |
|--------------------------|----------------|-----------------------------|--------|----------------|
| Name | LAST | FIRST | MIDDLE | MARITAL STATUS |
| Address | STREET | CITY | STATE | ZIP CODE |
| How long at this address | Home Telephone | Work Telephone | | |
| Social Security # | Birthdate | Relationship to Patient | | |
| Employer | Occupation | # of year(s) employed there | | |

SPOUSE'S INFORMATION

| | | | | |
|--------------------------|----------------|-----------------------------|--------|----------------|
| Name | LAST | FIRST | MIDDLE | MARITAL STATUS |
| Address | STREET | CITY | STATE | ZIP CODE |
| How long at this address | Home Telephone | Work Telephone | | |
| Social Security # | Birthdate | Relationship to Patient | | |
| Employer | Occupation | # of year(s) employed there | | |

MEDICAL HISTORY

Please check box if patient has or has had:

| | | | |
|------------------|---|--|---|
| Joint swelling | <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Bone disorders | <input type="checkbox"/> <input type="checkbox"/> | Prolonged bleeding | <input type="checkbox"/> <input type="checkbox"/> |
| Rheumatic fever | <input type="checkbox"/> <input type="checkbox"/> | Faintness/dizziness | <input type="checkbox"/> <input type="checkbox"/> |
| Thyroid problems | <input type="checkbox"/> <input type="checkbox"/> | Tonsils removed | <input type="checkbox"/> <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> <input type="checkbox"/> | Endocrine problems | <input type="checkbox"/> <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> <input type="checkbox"/> | Adenoids removed | <input type="checkbox"/> <input type="checkbox"/> |
| Contact lenses | <input type="checkbox"/> <input type="checkbox"/> | Emotional problems | <input type="checkbox"/> <input type="checkbox"/> |
| AIDS | <input type="checkbox"/> <input type="checkbox"/> | Pregnant <i>(now or in next 2 yrs)</i> | <input type="checkbox"/> <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> | Kidney involvement | <input type="checkbox"/> <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> <input type="checkbox"/> | | |

List any other serious illnesses _____

Physician's Name _____

List any allergies _____

Is patient under physician's care presently? List reason. _____

Please check box:

| | |
|---|---|
| Any injuries to face, mouth, teeth? | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Thumb, finger, lip sucking? | <input type="checkbox"/> <input type="checkbox"/> |
| Mouth-breathing when asleep, awake? | <input type="checkbox"/> <input type="checkbox"/> |
| Any missing permanent teeth? | <input type="checkbox"/> <input type="checkbox"/> |
| Any extra permanent teeth? | <input type="checkbox"/> <input type="checkbox"/> |
| Any teeth removed by extraction? | <input type="checkbox"/> <input type="checkbox"/> |
| Is there a tongue thrust problem? | <input type="checkbox"/> <input type="checkbox"/> |
| Any speech problems? | <input type="checkbox"/> <input type="checkbox"/> |
| Any pain or clicking on opening mouth? | <input type="checkbox"/> <input type="checkbox"/> |
| Does patient visit dentist regularly? | <input type="checkbox"/> <input type="checkbox"/> |
| Date of last dental visit? | _____ |
| Has an orthodontist been consulted previously? | |
| Reason: | _____ |
| Has your dentist pointed to some orthodontic problem? | |
| What? | _____ |

Hobbies and interests of patient: _____

Preferred method of payment: Cash Check Visa/Mastercard

Signature (Parent's signature required, if minor) _____

PLEASE PROVIDE INSURANCE INFORMATION ON THE BACK

