Patient#______________

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PATIENT INFORMATION

Date ______________

Last Name	First	Nickname	Birthdate	Age	M F (circle one)
Address	City	Zip Code	Telephone	School	
Email	Patient's Dentist				

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 ______________

Referred by ______________

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:

	Y	N		Y	N
Joint swelling	❑	❑	Epilepsy	❑	❑
Bone disorders	❑	❑	Prolonged bleeding	❑	❑
Rheumatic fever	❑	❑	Faintness/dizziness	❑	❑
Thyroid problems	❑	❑	Tonsils removed	❑	❑
Diabetes	❑	❑	Endocrine problems	❑	❑
Hepatitis	❑	❑	Adenoids removed	❑	❑
Contact lenses	❑	❑	Emotional problems	❑	❑
AIDS	❑	❑	Pregnant *(now or in next 2 yrs)*	❑	❑
Tuberculosis	❑	❑	Kidney involvement	❑	❑
Anemia	❑	❑			

List any other serious illnesses

Physician's Name

List any allergies

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

Please check box:

	Y	N
Any injuries to face, mouth, teeth?	❑	❑
Thumb, finger, lip sucking?	❑	❑
Mouth-breathing when asleep, awake?	❑	❑
Any missing permanent teeth?	❑	❑
Any extra permanent teeth?	❑	❑
Any teeth removed by extraction?	❑	❑
Is there a tongue thrust problem?	❑	❑
Any speech problems?	❑	❑
Any pain or clicking on opening mouth?	❑	❑
Does patient visit dentist regularly?	❑	❑

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

Insured's Name ______

Insured's Social Security # ______ Birthdate ______

Insurance Company ______

Group No. ______ Local No. ______

Insurance Company's Address ______

______

Ortho Coverage ______ Medical Coverage ______

Telephone Number ______

Dentition X - extracted S - supernumerary I - impaction D - decalcification O - congenitally missing Δ - atypical form

																Caries
RIGHT																LEFT
																Caries