Welcome to our office. Please fill out both sides of this form.

About You:

Today's Date: ____/____/________

Name: ____________________

I prefer to be called: ____________________

Birthdate: ___/___/_____ Age: ________ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: ____________________

City State Zip Code

Hm #: (   ) __________ Cell #: (   ) __________

E-mail Address: ____________________

Preferred Mode of contact: ____________________

DL #: ______________ State: ________

Employer: ____________________

Wk #: (   ) ______________

Whom may we thank for you referring you?:

Other family members seen by us:

Spouse/Emergency Contact Information:

Name: ____________________

Relation: ____________________

Hm #: (   ) __________ Cell #: (   ) __________

Address: ____________________

City State Zip Code

Employer: ____________________

Person Responsible for Account:

☐ Self ☐ Other

Name: ______________ Relation: ________

Billing Address: ____________________

City State Zip Code

Hm #: (   ) __________ Cell #: (   ) __________

Email: ____________________

Preferred method to contact: ____________________

Employer: ____________________

Driver's License #: ______________ State: ________

Insurance Information:

Primary

Orthodontic Coverage?: ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co Phone #: ____________________

Policy/Subscriber ID: ____________________

Policy Holder's Name: ____________________

Relationship to Patient: ____________________

Policy Holder's Birthdate: ___/___/________

Policy Holder's SS #: ____________________

Policy Holder's Employer: ____________________

Secondary

Orthodontic Coverage?: ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co Phone #: ____________________

Policy/ Subscriber ID: ____________________

Policy Holder's Name: ____________________

Relationship to Patient: ____________________

Policy Holder's Birthdate: ___/___/________

Policy Holder's SS #: ____________________

Policy Holder's Employer: ____________________

Dental History:

General Dentist: ___

Last Visit: ___

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

If Yes, When: ___

Have there been any injuries to the face, mouth, teeth, or chin? ☐ Yes ☐ No

If So, When: ___

Have you been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Have you ever had any pain/tenderness in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

What are the main concerns that you would like orthodontics to accomplish? ___

___

Do you have any of the following habits?

- ☐ Clenching/Grinding Teeth
- ☐ Lip Sucking/Biting
- ☐ Thumb/Finger Sucking
- ☐ Tongue Thrust
- ☐ Speech Problems
- ☐ Mouth Breathing

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

___

Signature Date

I authorize doctor or designated staff to take x-rays deemed appropriate to make a thorough diagnosis of orthodontic needs: ☐ Yes ☐ No

___

Signature Date

Medical History:

Have you ever had:

- ☐ Y ☐ No Abnormal Bleeding
- ☐ Y ☐ No ADD/ADHD
- ☐ Y ☐ No Diabetes
- ☐ Y ☐ No Asthma
- ☐ Y ☐ No Bone Disorders
- ☐ Y ☐ No Handicaps/Disabilities
- ☐ Y ☐ No AIDS/HIV
- ☐ Y ☐ No Epilepsy
- ☐ Y ☐ No Kidney Problems
- ☐ Y ☐ No Liver Problems
- ☐ Y ☐ No Hepatitis
- ☐ Y ☐ No Lupus
- ☐ Y ☐ No Heart Condition
- ☐ Y ☐ No Tuberculosis
- ☐ Y ☐ No Sickle Cell Disease
- ☐ Y ☐ No Allergic to Latex/Metals
- ☐ Y ☐ No Allergies to any Drugs
- ☐ Y ☐ No Food Allergy

If yes to above, please give details: ___

Your physician: ___

Are you currently under the care of a physician? ☐ Y ☐ N

Please list all medications you are currently taking:

Are you currently taking a bisphosphonate for osteoporosis? ☐ Y ☐ N

If so, which ones: ___

Please list any additional health information we should know: ___

For Woman:

Are you pregnant? ☐ Yes ☐ No Week #: ___

Are you nursing? ☐ Yes ☐ No

Additional person we may discuss medical and financial information with:

Name: ___ Relation: ___

☐ Medical ☐ Financial