PATIENT INFORMATION

Patient's Last Name | Patient's First Name | Patient Prefers to be Called | M / F

Patient's DOB | Patient's Age | Patient's E-Mail Address | Patient's Social Security #

Patient's Street Address | Patient's City, State, Zip | Patient's Home # | Patient's Cell #

Are other family members treated here Y / N | If so, who?

Other Sibling/Child Full Name | M / F | Sibling/Child DOB | Other Sibling/Child Full Name | M / F | Sibling/Child DOB

Patient's Dentist | Date of last dental cleaning

Whom may we thank for referring you to our office? | If patient is a minor, parent or legal guardian's name

RESPONSIBLE PARTY INFORMATION

Resp. Party's Last Name | Resp. Party's First Name | Resp. Party's E-mail Address | Relationship to Patient

Resp. Party's Street Address | City, State, Zip | Resp. Party's Home # | Resp. Party's Work # | Resp. Party Cell #

How long at this address? | Marital Status: Single Married Divorced Widowed Separated

Resp. Party's Social Security # | Resp. Party's Employer | Resp. Party's Occupation | # Yrs at Employer | Resp. Party's DOB

Previous Street Address (if less than 3 years at current address) | Previous City, State, Zip

Resp. Party's Spouse/Partner | Relationship to Patient | Spouse/Partner Employer | Spouse/Partner Occupation | # Yrs at Employer

Resp. Party's Spouse/Partner DOB | Spouse/Partner Social Security # | Spouse/Partner Work # | Spouse/Partner Cell #

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Last Name | Insured's First Name | Insured's Member # | Insurance Co. Name | Insured's Group #

Insurance Co.'s Street Address | Insurance Co.'s City, State, Zip | Insurance Co.'s # | Insured's' Employer | Insured's DOB

Do you have dual insurance coverage? Yes No **Do you have a pre-tax flexible spending account? Yes No**

EMERGENCY INFORMATION – RELATIVE OR FRIEND NOT LIVING WITH YOU

Medical Emergency Contact's Name | Street Address | City, State, Zip

Relationship to Patient | Emergency Contact's Home # | Emergency Contact's Work # | Emergency Contact's Cell #

Has an orthodontist been previously consulted? ☐ yes ☐ no	Are antibiotics necessary for dental cleanings? ☐ yes ☐ no	Has patient ever taken bisphosphonates (Aredia, Zometa, Fosamax, Actonel, or Boniva)? ☐ yes ☐ no
List any drugs/things that patient is allergic to or has a reaction to:	List any medications currently taking:	Physician's Name:
What is your dentist's main orthodontic concern?	Is there any dental work needing to be completed prior to orthodontic treatment? ☐ yes ☐ no If yes, please explain:	Is patient under the care of a physician at this time? ☐ yes ☐ no If yes, please explain:
Indicate the patient's feelings toward orthodontic treatment? ☐ Excited to get started ☐ Complacent ☐ Not committed	Indicate the patient's reasons for seeking orthodontic treatment? ☐ Esthetics ☐ Dental Function ☐ Overall Health	Please describe your orthodontic concerns and what you would like accomplished?

Personality Assessment	Office use:
Please check all that describe patient: ☐ Nervous ☐ Shy ☐ Sensitive ☐ Serious ☐ Calm ☐ Outgoing ☐ Afraid ☐ Humorous ☐ Confident ☐ Uncooperative ☐ Cooperative	BP:_____/_____ P:_____ Date:_____ BP:_____/_____ P:_____ Date:_____

Please check yes or no if patient currently has or has had:

Abnormal adenoids / tonsils ☐ yes ☐ no	Endocrine problems ☐ yes ☐ no	Organ transplant ☐ yes ☐ no
ADD / ADHD ☐ yes ☐ no	Epilepsy ☐ yes ☐ no	Osteoporosis ☐ yes ☐ no
AIDS / HIV ☐ yes ☐ no	Faintness / dizziness ☐ yes ☐ no	Physical disabilities ☐ yes ☐ no
Allergy/sinus trouble ☐ yes ☐ no	Fever blisters ☐ yes ☐ no	Prolonged bleeding ☐ yes ☐ no
Anemia ☐ yes ☐ no	Headaches (frequent) ☐ yes ☐ no	Psychiatric problems ☐ yes ☐ no
Arthritis ☐ yes ☐ no	Heart murmur ☐ yes ☐ no	Radiation/chemo/blood therapy ☐ yes ☐ no
Artificial heart valves ☐ yes ☐ no	Heart problems ☐ yes ☐ no	Respiratory problems ☐ yes ☐ no
Asthma ☐ yes ☐ no	Finger / thumb / lip sucking ☐ yes ☐ no	Rheumatic/scarlet/yellow fever ☐ yes ☐ no
Autism ☐ yes ☐ no	Hemophiliac ☐ yes ☐ no	Scoliosis ☐ yes ☐ no
Bone disorders ☐ yes ☐ no	Hepatitis ☐ yes ☐ no	Shortness of breath ☐ yes ☐ no
Blood disease ☐ yes ☐ no	Herpes ☐ yes ☐ no	Stroke ☐ yes ☐ no
Cancer ☐ yes ☐ no	High / low blood pressure ☐ yes ☐ no	Thyroid problems ☐ yes ☐ no
Cardiac pacemaker ☐ yes ☐ no	Jaundice ☐ yes ☐ no	TMJ problems ☐ yes ☐ no
Chronic cough ☐ yes ☐ no	Joint swelling ☐ yes ☐ no	Tonsils removed ☐ yes ☐ no
Diabetes ☐ yes ☐ no	Kidney disease ☐ yes ☐ no	Tuberculosis ☐ yes ☐ no
Down syndrome ☐ yes ☐ no	Liver disease ☐ yes ☐ no	Venereal disease ☐ yes ☐ no
Drug addiction ☐ yes ☐ no	Muscle / joint disorder ☐ yes ☐ no	Whiplash ☐ yes ☐ no
Ear problems ☐ yes ☐ no		Wound healing problems ☐ yes ☐ no
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Is the patient pregnant? ☐ yes ☐ no	Is bite uncomfortable? ☐ yes ☐ no	Cheek, tongue or lip chewing? ☐ yes ☐ no
Has patient reached puberty? ☐ yes ☐ no	Jaw symptoms/headaches? ☐ yes ☐ no	Clenching teeth? ☐ yes ☐ no
Any facial injuries? ☐ yes ☐ no	Trauma to the jaw? ☐ yes ☐ no	Grinding teeth? ☐ yes ☐ no
Mouth breathing? ☐ yes ☐ no	Does the patient smoke? ☐ yes ☐ no	Fingernail habit? ☐ yes ☐ no
Missing/extra permanent teeth? ☐ yes ☐ no	Abnormal height or weight? ☐ yes ☐ no	Food Allergies? ☐ yes ☐ no
Speech problems? ☐ yes ☐ no	Adopted? Does he/she know? ☐ yes ☐ no	Latex allergy? ☐ yes ☐ no
Pain/clicking upon opening mouth? ☐ yes ☐ no		

Please explain ANY diseases, medical or dental conditions that are not mentioned above:

Patient or responsible party signature (if minor) **Date**

CONSENT: The undersigned hereby authorizes the doctor to take x-rays, study models, photographs in order to make a thorough diagnosis of the patient's orthodontic needs. It is my responsibility to inform this office immediately of any changes in medical status. I understand that when appropriate credit bureau reports may be obtained.