



# SIMISTER ORTHODONTICS

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Date \_\_\_\_\_

## Confidential Responsible Party Information

Name \_\_\_\_\_ Marital Status \_\_\_\_\_

Last First Middle

Residence \_\_\_\_\_

Street City State Zip

Mailing Address \_\_\_\_\_

Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 years) \_\_\_\_\_

Street City State Zip

E-mail Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Last First Middle

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

## Confidential Patient Information

Patient's Name \_\_\_\_\_

Last First Middle

Address \_\_\_\_\_

Street City State Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

## Insurance Information

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Do you have dual coverage?  Yes  No If yes:

Policy Holder's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Co. Phone \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (Date & Initial) \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

## MEDICAL HISTORY

GENERAL DENTIST \_\_\_\_\_ LAST CLEANING \_\_\_\_\_

IS PATIENT IN GOOD HEALTH? \_\_\_\_\_  YES  NO

DOES PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS \_\_\_\_\_  YES  NO

PLEASE LIST \_\_\_\_\_

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED

AIDS & HIV..... <input type="checkbox"/>	Anemia..... <input type="checkbox"/>	Prolonged Bleeding..... <input type="checkbox"/>
Diabetes..... <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>	Fainting or Dizziness..... <input type="checkbox"/>
Pneumonia..... <input type="checkbox"/>	Asthma..... <input type="checkbox"/>	Nervous disorders..... <input type="checkbox"/>
Heart Trouble..... <input type="checkbox"/>	Kidney Involvement..... <input type="checkbox"/>	Hepatitis..... <input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/>	Tuberculosis..... <input type="checkbox"/>	Endocrine Problems..... <input type="checkbox"/>
Bone Disorders..... <input type="checkbox"/>		

DOES PATIENT HAVE TENDENCY TO COLDS?  SORE THROATS?  EAR INFECTIONS?

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? \_\_\_\_\_  YES  NO

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS \_\_\_\_\_

LIST ANY ALLERGIES OR DRUG SENSITIVITY \_\_\_\_\_

HAS THE PATIENT REACHED PUBERTY? GIRLS - HAS SHE STARTED MENSTRUATION?  YES  NO

BOYS - HAS HIS VOICE CHANGED?  YES  NO

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

## DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? \_\_\_\_\_  YES  NO

HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? \_\_\_\_\_  YES  NO

DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? \_\_\_\_\_  YES  NO

IS THE PATIENT A MOUTH BREATHER? WHILE AWAKE? \_\_\_\_\_  YES  NO

WHILE ASLEEP? \_\_\_\_\_  YES  NO

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? \_\_\_\_\_  YES  NO

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? \_\_\_\_\_  YES  NO

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? \_\_\_\_\_  YES  NO

LIST ANY MUSICAL INSTRUMENTS PLAYED \_\_\_\_\_

REASON FOR CONSULTATION \_\_\_\_\_