



Responsible Party Information

Name _____ Marital Status _____
Mailing Address _____
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 years) _____
Email Address _____ Cell Phone _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ Years Employed _____
Spouse's Name _____ Relationship to Patient _____
Employer _____ Occupation _____ Years Employed _____
Social Security # _____ Birthdate _____ Relationship to Patient _____

Patient Information

Patient's Name _____
Address _____
Home Phone _____ Birthdate _____ Social Security # _____
If patient is a minor, give parent or guardian's name _____
Whom may we thank for referring you to our office? _____

Insurance Information

Policy Holder's Name _____ Birthdate _____ Social Security # _____
Primary Insurance Company _____ Group # _____ Member ID # _____
Insurance Co. Address _____ Insurance Co. Phone _____
Policy Holder's Employer _____
Policy Holder's Name _____ Birthdate _____ Social Security # _____
Secondary Insurance Company _____ Group # _____ Member ID # _____
Insurance Co. Address _____ Insurance Co. Phone _____
Policy Holder's Employer _____

I authorize the release of my information relating to any insurance claim, to my insurance company. I understand that I am responsible for all costs of orthodontic treatment. I hereby authorize payment directly to the above named orthodontist or the group insurance benefits otherwise payable to me.

Signature (Parent's signature if minor) _____ Date _____

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

AIDS.....

Anemia.....

Prolonged Bleeding.....

Diabetes.....

Epilepsy.....

Fainting or Dizziness.....

Pneumonia.....

Asthma.....

Nervous Disorders.....

Heart Trouble.....

Kidney Involvement.....

Hepatitis.....

Rheumatic Fever.....

Tuberculosis.....

Endocrine Problems.....

Bone Disorders.....

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 currently 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 _____