

Patient Information

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Patient Last Name

Patient First Name

Prefers to Be Called

M/F

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Patient DOB

Patient Age

Patient Soc. Sec. #

Patient Home #

Patient Cell #

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Patient Street Address

Patient City, State Zip

Family E-Mail Address

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Other Sibling/Child Full Name

M/F

DOB

Other Sibling/Child Full Name

M/F

DOB

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Whom may we thank for referring you to our office?

If patient is a minor, parent or legal guardian name

Responsible Party Information

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Resp. Party Last Name

Resp. Party First Name

Relationship to Patient

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Resp. Party Street Address

City, State Zip

Resp. Party Home #

Resp. Party Cell #

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How Long at Address

Marital Status: Single, Married, Divorced, Widowed, Separated

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Resp. Party SSN

Resp. Party DOB

Resp. Party Employer

Years at Employment

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Resp. Party Spouse/Partner

Relationship to Patient

Resp. Party Spouse/Partner Cell #

Primary Dental Insurance Information

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Insured's Last Name

Insured's First Name

Insured's Soc. Sec. #

Insured's DOB

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Insurance Company

Insurance Co. Phone #

Insurance Co.'s Address

Insured's Employer

Emergency Information – Relative or Friend

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Emergency Contact's Name

Cell #

Work #

Home #

| Orthodontic | Dental | Medical |
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| Has an orthodontist been previously consulted? | Dentist Name: What was your dentist main concern? | Physician's Name: Date of last physical exam: |
| In your own words, describe your orthodontic problems and what you would like orthodontics to accomplish? | Is there any dental work needing to be completed prior to orthodontic treatment? <input type="radio"/> Yes <input type="radio"/> No | Has patient been under the care of a Physician in the last two years? If yes, please explain: |
| Please tell us the patient's feelings toward orthodontic treatment? <input type="radio"/> excited to get started <input type="radio"/> nervous/anxious <input type="radio"/> not committed to cooperate | Do you or have you ever required antibiotics needed for teeth cleanings? <input type="radio"/> Yes <input type="radio"/> No | List any medications being taken at this time: |
| Hobbies/Comments: | What was the date of patient's last cleaning? | List any drugs/things the patient is allergic to or has a reaction to: |

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please Check all that apply)

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| AIDS/HIV Infection | <input type="checkbox"/> | Chemotherapy | <input type="checkbox"/> | Frequent Cough | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | Psychiatric Disease | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | Cold Sores | <input type="checkbox"/> | Frequent Diarrhea | <input type="checkbox"/> | Hypoglycemia | <input type="checkbox"/> | Radiation Treatment | <input type="checkbox"/> |
| Alzheimer's Disease | <input type="checkbox"/> | Depression | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | Intestinal Disease | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Heart Attack/Failure | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | Sickle Cell Disease | <input type="checkbox"/> |
| Angina/Chest Pain | <input type="checkbox"/> | Dialysis | <input type="checkbox"/> | Heart Surgery | <input type="checkbox"/> | Joint Disease | <input type="checkbox"/> | Sinus Trouble | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | Dramatic Weight Loss | <input type="checkbox"/> | Heart Trouble/Disease | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | Stomach Disease | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Drug Addiction/Use | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | Leukemia | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | Hepatitis A | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Breathing Problems | <input type="checkbox"/> | Excessive Bleeding | <input type="checkbox"/> | Hepatitis B | <input type="checkbox"/> | Low Blood Pressure | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> |
| Bruise Easily | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | Hepatitis C | <input type="checkbox"/> | Lung Disease | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> |
| Cancer/Tumors | <input type="checkbox"/> | Fever Blisters | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | Parathyroid Disease | <input type="checkbox"/> | No Medical Problems | <input type="checkbox"/> |

PLEASE EXPLAIN ALL CHECKED RESPONSES: _____

ANY OTHER MEDICAL PROBLEM OR ILLNESS NOT CHECKED ABOVE PLEASE EXPLAIN _____

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.

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