Patient Information

Name (First, M, Last) ___________________________________DOB ___________________Gender M / F

Address ____

City _____________________________________State________Zip_______________________________

Cell Phone # ________________________ (mom/dad) Cell Phone #________________________ (mom/dad)

Email ____OK to send emails? Yes / No

Dentist's name______________________________________ Date of last visit_______________________

List the names of any friends/family currently in the practice______________________________________

How did you hear about us? Google __Yelp__ Friend________________Dr.___________________________

List any sports, hobbies, or musical instruments played:____

Whom may we thank for referring you to our practice?____

Insurance Information

Insurance Co.__________________________________ Phone #___________________________________

Address ____

City ____State________Zip___________________________

Subscribers name (First, M, Last) _____________________________DOB_____________________________

Subscriber SSN# ___________________________Patients SSN# ___________________________________

Subscriber ID#_______________________________Group#_______________________________________

Employer____

Office Use Only
Lifetime Max __________ % paid_______________ Payout Mthly/Quarterly/Yearly Initial payout____________

Dental and Medical History

Has the patient had an orthodontic consult or treatment	Yes/No	If so, when?	

What is the main orthodontic concern? ____

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List of Medications: ____

Do you have a latex allergy?____

Speech Problems/Therapy	Yes/No	Grind or clench teeth?	Yes/No
Injury to face, jaw, teeth, or mouth?	Yes/No	Discomfort from teeth or gums?	Yes/No
Pain, tenderness, or noise in either jaw?	Yes/No	Frequent headaches?	Yes/No
Oral Habits (thumb/finger sucking or lip/nail biting?	Yes/No	Neck/shoulder pain?	Yes/No
Frequent sore throats?	Yes/No	Brush teeth daily?	Yes/No
Floss teeth daily?	Yes/No	Fluoride treatments?	Yes/No
Mouth breathing?	Yes/No	Snores during sleep?	Yes/No
Requires premedication?	Yes/No	Any missing or extra permanent teeth?	Yes/No
Apprehensive about dental care?	Yes/No	Frequently chew gum?	Yes/No
Rheumatic Fever	Yes/No	Tuberculosis/Lung disease	Yes/No
Pneumonia	Yes/No	Liver disease	Yes/No
Kidney disease	Yes/No	Heart Attack/Stroke	Yes/No
Heart disease	Yes/No	Congenital Heart Defect	Yes/No
Heart Murmur	Yes/No	Hemophilia	Yes/No
Hypertension/High blood pressure	Yes/No	Prolonged Bleeding/Transfusion	Yes/No
Anemia	Yes/No	HIV/AIDS	Yes/No
Hepatitis	Yes/No	Tonsils/Adenoids removed	Yes/No
Cancer	Yes/No	Family history of Cancer	Yes/No
Received radiation treatment	Yes/No	Growth Problems	Yes/No
Endocrine problems	Yes/No	Hormone Therapy	Yes/No
Metal allergy	Yes/No	Nervous disorders	Yes/No
Bone disorders/Bone loss	Yes/No	Diabetes	Yes/No
Seizures/Epilepsy	Yes/No	Handicaps/Disabilities	Yes/No
Treated for emotional problems	Yes/No	Arthritis	Yes/No

Signature: ____ Date: ________________