



Patient Information

Date _____

Patient's Name _____

Address _____ City _____ Zip _____

Home Phone _____ DOB ____/____/____ Age ____ yr. ____ mo. Sex _____

School _____ Grade _____

Whom may we thank for referring you to our office? _____

General Dentist _____ City _____

Siblings: Name _____ DOB ____/____/____ Name _____ DOB ____/____/____

Name _____ DOB ____/____/____ Name _____ DOB ____/____/____

Responsible Party Information

Father's Name _____ **Biological** _____ **Other** _____

Address _____ City _____ How Long? ____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ - _____ - _____ DOB ____/____/____

Employer _____ Occupation _____ How Long? ____

Mother's Name _____ **Biological** _____ **Other** _____

Address _____ City _____ How Long? ____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security Number _____ - _____ - _____ DOB ____/____/____

Employer _____ Occupation _____ How Long? ____

Person financially responsible for this account _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

Signature _____

Date _____

Orthodontic Insurance Information

Insured's Name _____ DOB ____/____/____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Phone _____

Do you have dual coverage? Yes No

2nd Insured's Name _____ DOB ____/____/____ SSN _____ - _____ - _____

Insurance Company _____ Group No. _____ Phone _____

Emergency Information

Name of Contact Person _____

Daytime Phone #'s _____

Medical History

Physician's Name _____ City _____

Does patient have a history of major illness or hospital stay? _____ Yes No

If so, circle which of the following the patient has been treated for:

ANEMIA	DIABETES	HEART PROBLEMS	RHEUMATIC FEVER
ARTHRITIS	EPILEPSY	HEPATITIS	SINUS PROBLEMS
ASTHMA	FAINTING/DIZZINESS	HERPES	TUBERCULOSIS
BLOOD DISORDERS	GLAUCOMA	HIV+/AIDS	OTHER
COLD SORES	HEARING LOSS	KIDNEY/LIVER	

Please explain _____

Have tonsils and adenoids been removed? What age? _____ Yes No

List any drugs or medications now being taken. _____

Please give reason. _____

List any allergies or sensitivities: (drugs, latex, metal, plastic, other) _____

Has patient reached puberty? Girl – Started Menstruation _____ Yes No

Boy – Voice Changed/Facial hair _____ Yes No

Dental History

Have there been injuries to the face, mouth, or teeth? _____ Yes No

Has the patient ever sucked a thumb or finger? Until what age? _____ Yes No

Is the patient a mouth breather? _____ Yes No

Does the patient have a tongue thrust? _____ Yes No

Does the patient have any speech problems? _____ 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 or siblings had orthodontic treatment? _____ Yes No

Has your child ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? _____ Yes No

WHAT WOULD YOU LIKE ORTHODONTICS TO ACCOMPLISH? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature _____ Date _____