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PATIENT INFORMATION

First Name		Last Name		Birthdate		Sex	Nickname
Mailing Address		City		State	Zip		Home Phone
Name of Dentist & City	Grade	Age	E-Mail	Patient lives with: Mother ☐ Father ☐ Both ☐			Cell Phone
Who may we thank for recommending us?							
Related patients that are or have been under our care: 1.				Names and ages of other children: 1.			
2.				2.			
3.				3.			
4.				4.			

PARENT / SPOUSE INFORMATION

Father's/Husband's Name ______________________	Mother's/Wife's Name ______________________
Address (if different from patient's) ______________________	Address (if different from patient's) ______________________
______________________	______________________
City ____________ St. ______ Zip ______	City ____________ St. ______ Zip ______
Home Phone ________ Work Phone ________	Home Phone ________ Work Phone ________
Cell Phone ____________ Fax ____________	Cell Phone ____________ Fax ____________
S.S # ____________ e-mail ____________	S.S # ____________ e-mail ____________
Employer ______________________	Employer ______________________
Address ______________________	Address ______________________
City ____________ St. ______ Zip ______	City ____________ St. ______ Zip ______

PERSON RESPONSIBLE FOR THIS ACCOUNT

Name			Relationship to patient		Employed by/Occupation
Mailing Address (if different from above)	City		State	Zip	S.S.#
Do you have Orthodontic Insurance? Yes ☐ No ☐ Name of Company:		Business Phone		Home Phone	Cell Phone

MEDICAL HISTORY

Date of last physical exam ______________________________________

Please check if patient has or has had:

Yes	No		Yes	No	
☐	☐	Joint swelling	☐	☐	Nervous disorder
☐	☐	Bone disorder	☐	☐	Brain injury
☐	☐	Joint prosthesis	☐	☐	Epilepsy (convulsions)
☐	☐	Heart trouble	☐	☐	Anemia
☐	☐	Mitral Valve Prolapse	☐	☐	Blood disorder
☐	☐	Rheumatic trouble	☐	☐	Faintness/Dizziness
☐	☐	Thyroid problems	☐	☐	Tonsils removed
☐	☐	Tuberculosis	☐	☐	Adenoids removed
☐	☐	Diabetes	☐	☐	Sore throats
☐	☐	Kidney or liver involvements	☐	☐	Tonsillitis
☐	☐	Emotional problems	☐	☐	Earaches
☐	☐	Arthritis			

On items checked "Yes" please provide us with a more detailed description:

DENTAL HISTORY

Date of last dental exam ______________________________________

Please check Yes or No:

Yes	No	
☐	☐	Any injuries to: face, mouth, teeth? (circle)
☐	☐	Thumb, finger, lip sucking? (circle)
☐	☐	More than average amount of decay?
☐	☐	Any missing permanent teeth?
☐	☐	Any extra permanent teeth?
☐	☐	Any teeth removed by extraction?
☐	☐	Any difficulty in swallowing or chewing?
☐	☐	Any pain or clicking on opening mouth?
☐	☐	Is patient adopted? At what age? __________
☐	☐	Has/is the patient had/having speech therapy?
☐	☐	Has an orthodontist been consulted previously?

Reason:

What would you like to have orthodontic treatment accomplish?

List any other serious illnesses:

List any allergies/drug allergies/metal allergies:

List drugs or medicines now being taken:

Is patient presently under physician's care?

Reason:

Name of physician:

Primary: Other:

Does the patient have any special problems not mentioned above?

Patient's attitude toward orthodontic treatment:

(Circle one) Very motivated Will cooperate if needed Not motivated

Adolescent Females: Has menstruation begun? ☐ Yes ☐ No

Date (month/year):

To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings, presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I understand that as the responsible party for this account, I assume full obligation for all charges that are incurred. I, the undersigned, agree to pay for all attorney fees and other costs of collections in the event it becomes necessary to use attorney services to secure payment of this account.

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Signature of Patient, Parent or Guardian Date

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