PATIENT INFORMATION

Name: _____
First Mi Last

Nickname: _____ Gender _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____/_____/_____

PARENT INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home: _____Work/Cell: _____

Relationship to Patient: _____

PARENT INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Home: _____Work/Cell: _____

Relationship to Patient: _____

SPOUSE INFORMATION ☐ N/A

Name: _____
First Mi Last

RESPONSIBLE PARTY INFORMATION

Name: _____
First Mi Last

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____-_____-_____

Insured's Birthdate: _____/_____/_____

Relationship to Patient: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DENTAL INSURANCE INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Group #: _____ Insurance ID: _____

Phone: _____

DENTIST NAME: _____

Physician Name: _____

Latex Allergy Y / N	Prolong Bleeding Y / N	Tobacco Use Y / N	Thumb/Finger Sucking Y / N
Heart Murmur Y / N	Poor Wound Healing Y / N	Gum Disease Y / N	Mouth Breathing Y / N
Hepatitis Y / N	History of Fainting Y / N	Missing Adult Teeth Y / N	Finger Nail Biting Y / N
Diabetes Y / N	Heart Disease Y / N	Jaw Joint Problems Y / N	Speech Problems Y / N
Anemia Y / N	High /Low Blood Pressure Y / N	Teeth Grinding Y / N	Tongue Thrust Y / N
Tuberculosis Y / N	Rheumatism/Arthritis Y / N		
Asthma Y / N	Facial Trauma Y / N	Current Medications_____	
Tumor/Cancer Y / N	Emotional Problems Y / N	Any Allergies _____	
Epilepsy Y / N	Is Patient Pregnant Y / N	Any Conditions Not Listed Above _____	

Whom May We Thank for Referring You to Our Office? _____

Have You Been Examined by an Orthodontist Before? _____ If Yes, When: _____

Have Other Members of the Family had Orthodontic Treatment in Our Office? _____ Are You Happy with the Results? _____

What are Their Names: _____

Describe Your Orthodontic Needs: _____

What Would You Like Orthodontic Treatment to Accomplish: _____

_____ _____ _____
Guardian/Parent Signature Date Adult Patient Signature