Patient Information

Patients name ______________________________ Date ______________
Last First M.I.

Street Address ______________________ City/State/Zip ______________________

Age _______ Birthdate ______________ Sex _______ Home Phone ____________ High School District ____________

If patient is a minor, give parent or guardians name ______________________________

Dentist ______________________ Whom may we thank for referring you to our office? ______________________

Physician ______________________ Are you under a physicians care? ________ Why? ______________________

Are you taking any medication presently? ________ If so, what? ______________________

Is there a history of	Patient	Family
Rheumatic Fever	________	________
Heart Disease	________	________
Diabetes	________	________
Epilepsy	________	________
Tuberculosis	________	________
HIV	________	________

Do you have trouble breathing through your nose? ______________

Are your tonsils and adenoids present? ______________

Any other operations? ______________

Allergies ______________

Have you had an accident or injury to your head or face? ______________

Do you have or have you had any jaw (joint) pain? ______________

Do you have face muscle pain? ______________

What is your main reason for seeing us? ______________________________

Responsible Party Information

Name ______________________________ Marital Status ______________
Last First M.I.

Street Address ______________________ City/State/Zip ______________________

Mailing Address ______________________ City/State/Zip ______________________

How long at this address? ________ Home phone ______________ Email ______________

Previous address (if less than 3 years) ______________________________

Birthdate ______________ Relationship to patient ______________ SS# ______________

Employer ______________ Occupation ______________ No. of years employed ________ Work Phone ______________

Spouse's Name ______________________________
Last First M.I.

Birthdate ______________ Relationship to patient ______________ SS# ______________

Employer ______________ Occupation ______________ No. of years employed ________ Work Phone ______________

Orthodontic Insurance Information

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Employer ______________ Group # ______________

Insurance Co. Address ______________________ Phone No. ______________

Do you have dual coverage? ❑ Yes ❑ No If yes:

Insured's Name ______________________ Insured's Soc. Sec. # ______________

Insurance Company ______________ Employer ______________ Group # ______________

Insurance Co. Address ______________________ Phone No. ______________

Signature / Parents signature if minor ______________________________

Updates (date & initials) ______________________________

CONFIDENTIAL (for record and pre-treatment evaluation)