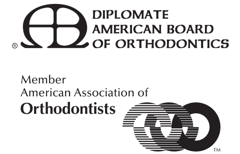

ORTHODONTIC PATIENT INFORMATION

Age:_______ Birth date: _________ Sex:______

Patients Name: ____

Home Address: ____
Street City State Zip Code

Home Phone: (____)__________________ Work Phone: (_____) _________________ SSN:___________________

Email Address: ____________________________________

PERSON RESPONSIBLE FOR ACCOUNT

Name: ____________________________ Relation to patient: ____________________________

Home Address: ____
Street City State Zip Code

How Long at Present Address: _________________

Home Phone: (____)__________________ Work Phone: (_____) _________________ SSN:___________________

(if less than 3 years, Previous Address)

Previous Address: ____
Street City State Zip Code

Marital Status:_______________________________

Employer: ______________________________ Occupation: ____________________________ How Long? _____

Spouses Name: _______________________________

Employer: ______________________________ Occupation: ____________________________ How Long? _____

SSN: ______________________________ Work Phone: ____________________________

INSURANCE INFORMATION

Insurance Company: __________________________________ Group No.: ____________________________

Insured's Name: ________________________________ Birth Date: ______________ SSN: ________________

Do you have dual coverage?__________________________ If yes, Insurance Co. ____________________________

Insured's Name: ________________________________ Birth Date: ______________ SSN: ________________

FAMILY STATUS

Patient's Occupation or School Level: _____________________ Name of School: ____________________________

Names & ages of other children in family:____

____

Patient Living with: PARENTS MOTHER FATHER SELF OTHER:______________

EMERGENCY INFORMATION

Name of Nearest Relative Not Living With You: ____

Previous Address: ______________________________________ Phone: (_____)______________________
Street City State Zip Code

Family Dentist: ______________________________________ Referred By:______________________________

Family Physician: ____

(over)

HEALTH INFORMATION

Is the patient under the care of a physician for a specific problem at this time? _____ YES _____ NO

Illness ____

List any medications currently being taken ____

List any drug allergies____

Is there a history of serious illness, accident, or operation? _____ YES _____ NO

If so, please explain____

PLEASE CHECK THE FOLLOWING AS THEY APPLY

______ Tuberculosis
______ Glaucoma
______ Heart trouble
______ Kidney disease
______ Hepatitis/Liver disease
______ High blood pressure
______ Head/Facial Injury
______ Tonsillitis
______ Hearing disorder
______ Allergies/Asthma
_______ Rheumatic fever
_______ Diabetes
_______ Bleeding problems
_______ Ear infections
_______ Speech problems
_______ Emotional problems
_______ Endocrine problems
_______ Nervous disorders
_______ Epilepsy
_______ Other:______________________________

PLEASE COMPLETE THE FOLLOWING TO HELP US EVALUATE FAMILY GROWTH PATTERN:

Father's height:______________ Mother's height:___________ Patient's height:______________ Weight: _____________

**FOR ADOLESCENT PATIENTS ONLY: (For Growth Assessment)

Has the patient reached puberty? ________ YES ________ NO

Girls: Has Menstruation started? ________ YES ________ NO

Boys: Secondary sex characteristic? Hair development? ________ YES ________ NO

DENTAL HISTORY

Have there been any injuries to the face, mouth, or teeth? ________ YES ________ NO

Has the patient ever sucked a thumb or fingers? ________ YES ________ NO

If yes, until what age? ________ YES ________ NO

Has an orthodontist been previously consulted? ________ YES ________ NO

Has the patient had previous orthodontic treatment? ________ YES ________ NO

If so, by whom? ________ YES ________ NO

Has either parent had orthodontic treatment? ________ YES ________ NO

Have you been informed of my missing or extra teeth? ________ YES ________ NO

Please list family members previously treated here ____

____

WHAT IS YOUR MAIN ORTHODONTIC CONCERN?

____

____

Any additional information which you feel would help make your child's association with us more enjoyable? _________

____

____

Signature of Patient/Parent/Guardian: ____

OFFICE USE ONLY: ____

____

____