GENERAL INFORMATION

Patient's Name ______________________________Birthdate ____________ Age_________ Sex _____________
Address____ Phone _________________________
City _______________________State_____________ Zip______________ Work/Cell Phone_________________
E-mail address____
May we contact you at work Yes______ No______ Email Yes_______ No_________

Father/Husband's Name ____ Work Phone _________________
Address____ Cell Phone _________________

Mother/Wife's Name ____Work Phone _________________
Address____Cell Phone _________________

Are Parents: Married_________ Widowed __________Separated _______Divorced________

May we contact you at work? Yes ( ) No ( )
Person responsible for account: ____
Does the family anticipate a move in the next 2-3 years? ______________________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Co.______________________ Phone #______________________Group #___________
Name of Subscriber______________________________ Social Security Number__________________________
Relationship to Patient_________________________Employer____________________Birthdate____________

Secondary Insurance Co.____________________ Phone # ____________________Group # _____________
Name of Subscriber___________________________ Social Security Number_____________________________
Relationship to Patient_________________________ Employer___________________Birthdate _____________

DENTAL HISTORY

Patient's reason for seeking orthodontic treatment:____
____
Patient's Dentist____________________________City_________________ Date last seen:________________

Referred by: ( ) General dentist ( ) Friend: ____
( ) Physician ( ) Other: ____

*****Please complete the back of this form also thanks.*****

	Y	N		Y	N
Clench the teeth	( )	( )	Have difficulty cleaning teeth	( )	( )
Grind the teeth	( )	( )	Still have adenoids	( )	( )
Chew or suck on fingers/lips	( )	( )	Still have tonsils	( )	( )
Have speech problems	( )	( )	Have any facial pain	( )	( )
Have frequent headaches	( )	( )	Noticed any clicking near the ears	( )	( )
Have difficulty opening mouth	( )	( )	Have noise/popping in jaw joint	( )	( )
Had any TMJ Treatment	( )	( )	Worn mouth-guard or splint	( )	( )
Breathe through mouth	( )	( )	Difficulty breathing through nose	( )	( )
Had dental extractions	( )	( )	Had teeth knocked out	( )	( )
Had injuries to jaw/teeth	( )	( )	Fallen on the face	( )	( )
Had surgery on face/jaw	( )	( )	Experienced bleeding of gums	( )	( )
Had any gum problems	( )	( )	Had mouth sores	( )	( )
Had difficult dental treatment	( )	( )	Had previous orthodontic treatment	( )	( )

Rate patient's health ( ) Excellent ( ) Good ( ) Fair ( ) Poor

	Y	N
Has the patient been under a physician's care in the past five years?	( )	( )
Has the patient been hospitalized or had any serious illness?	( )	( )
Has the patient had any reaction to local or general anesthesia?	( )	( )
Has the patient had any change in health in the past five years?	( )	( )
Has the patient reached puberty?	( )	( )
Has the patient ever been pregnant or are they pregnant now?	( )	( )
Has the patient ever had a blood transfusion?	( )	( )
Has the patient experienced excessive bleeding with dental/surgical treatment?	( )	( )
Does the patient have to be pre-medicated for dental visits?	( )	( )
Is patient **allergic to any medication** or substances?	( )	( )

If yes, name the medication or substance:____

Has the patient contracted or been exposed to the following:

Y	N		Y	N		Y	N	
( )	( )	Allergies	( )	( )	Convulsions	( )	( )	Asthma
( )	( )	Endocrine disturbance	( )	( )	Prosthetic heart valve	( )	( )	Tuberculosis
( )	( )	Auto accident injury	( )	( )	Epilepsy	( )	( )	Prosthetic joint
( )	( )	Birth defects	( )	( )	Growth disturbance	( )	( )	Rheumatic fever
( )	( )	Breathing problems	( )	( )	Heart murmur	( )	( )	Scarlet fever
( )	( )	Chronic pain	( )	( )	Injured during sports	( )	( )	Severe headaches
( )	( )	HIV / AIDS	( )	( )	Hepatitis			

Name medications taken previously:____
Name medications currently taking:____
Patient's Physician____________________________City________________Date last seen________

I consent to the making of orthodontic records as part of my treatment. I agree to be responsible for any charges and allow this office to file insurance on my behalf. In the event it becomes necessary to turn this account over to collections, I understand that I will pay a reasonable attorney's fee and collection cost.

Signature of responsible party____

Relationship to patient______________________________________Date____________________