

PATIENT INFORMATION

Patient's name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex: F [ ] M [ ]  
Home Address \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ How long at address \_\_\_\_\_  
Home Phone \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_  
Patient's hobbies \_\_\_\_\_  
**Parents'** marital status \_\_\_\_\_ Custodial parent's name \_\_\_\_\_  
Names and ages of other children in family \_\_\_\_\_  
General Dentist \_\_\_\_\_ Physician \_\_\_\_\_  
Who may we thank for referring you to our office? \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION (custodial parent only)

Name \_\_\_\_\_ Marital status \_\_\_\_\_  
Home Address \_\_\_\_\_ Own [ ] Rent [ ]  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ How long at address \_\_\_\_\_  
Previous Address (if less than 3 years) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_ Relationship to patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

**Responsible Party Email:** \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_/\_\_\_/\_\_\_  
Relationship to patient \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

DENTAL INSURANCE INFORMATION

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS/ID # \_\_\_\_\_

**Signature of Insured for Assignment of Benefits** \_\_\_\_\_

Employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ Group # \_\_\_\_\_

Do you have dual coverage? YES [ ] NO [ ]

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_ SS/ID # \_\_\_\_\_

**Signature of Insured for Assignment of Benefits** \_\_\_\_\_

Employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_ Group # \_\_\_\_\_

EMERGENCY INFORMATION

Name of nearest **relative not living with you** \_\_\_\_\_ (relationship) \_\_\_\_\_  
Address \_\_\_\_\_ Home phone \_\_\_\_\_  
City, State \_\_\_\_\_ Zip \_\_\_\_\_ Work phone \_\_\_\_\_

I understand the information I have given is correct and I authorize the dental team to perform the necessary dental services my child may need. I understand where appropriate, credit bureau reports may be obtained.

Signature (parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

## MEDICAL INFORMATION

**Please check box if patient has or had any of the following:**

Allergies - List: _____	HIV (tested positive)/AIDS	<input type="checkbox"/>
Anemia <input type="checkbox"/>	Liver/Kidney Problem	<input type="checkbox"/>
Asthma <input type="checkbox"/>	Nervous/Hyperactive	<input type="checkbox"/>
Blood Transfusion <input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>
Bone Disorder <input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>
Cancer <input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>
Convulsions <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Emotional Problems <input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>
Artificial Bones/Joints/Valves <input type="checkbox"/>	Removal of Tonsils/Adenoids	<input type="checkbox"/>
Endocrine/Thyroid Problem <input type="checkbox"/>		
Fainting <input type="checkbox"/>		
Fever Blisters/Herpes <input type="checkbox"/>		
Frequent Headaches <input type="checkbox"/>		
Glaucoma <input type="checkbox"/>		
Handicaps/Disabilities <input type="checkbox"/>		
Hearing Problems <input type="checkbox"/>		
Heart Problems <input type="checkbox"/>		

Is Patient in good health? **YES / NO**      Is Patient under a physician's care? **YES / NO**

If yes, for what reason \_\_\_\_\_

Are there any impending medical conditions? **YES / NO**

If yes, describe \_\_\_\_\_

Is Patient taking prescription medications? **YES / NO**

If yes, list \_\_\_\_\_

For children and adolescence only

Has puberty been reached? (start of menstruation or voice change) **YES / NO**

If yes, has it been within the last two years? **YES / NO**

## DENTAL HISTORY

	YES	NO		YES	NO
Has Patient had a recent dental check-up?	<input type="checkbox"/>	<input type="checkbox"/>	Date _____		
Any missing teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Any extra teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Any night time clenching or grinding habit?	<input type="checkbox"/>	<input type="checkbox"/>	Clicking/locking or pain when opening jaws?	<input type="checkbox"/>	<input type="checkbox"/>
Any speech problems?	<input type="checkbox"/>	<input type="checkbox"/>	Surgery to repair cleft lip and/or cleft palate?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent mouth breathing?(awake/sleeping)	<input type="checkbox"/>	<input type="checkbox"/>	Has Patient ever seen an orthodontist?	<input type="checkbox"/>	<input type="checkbox"/>
Does Patient snore or have difficulty breathing during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	Has Patient ever sucked thumb or finger?	<input type="checkbox"/>	<input type="checkbox"/>
Have any primary/permanent teeth been removed by extraction?	<input type="checkbox"/>	<input type="checkbox"/>		<b>YES</b>	<b>NO</b>
Has either parent had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Family history of short rooted teeth?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Has Patient been diagnosed with tongue thrust?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Family history of tongue thrust?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Family history of tongue tied or high frenum attachments?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Is Patient sensitive or self-conscious about his/her teeth?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Is Patient adopted?	<input type="checkbox"/>	<input type="checkbox"/>	Does he/she know? <b>YES / NO</b>		
Does Patient resemble mother and/or father? (please circle)			M	F	
Does anyone in family have similar dental conditions?	<input type="checkbox"/>	<input type="checkbox"/>			
Would Patient mind wearing braces?	<input type="checkbox"/>	<input type="checkbox"/>			
Has a dentist ever placed a retainer or space maintainer?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you understand some appointments will need to be scheduled during work/school hours?	<input type="checkbox"/>	<input type="checkbox"/>			
Has your child been bullied due to his/her smile?	<input type="checkbox"/>	<input type="checkbox"/>			
What are the main concerns you would like orthodontics to accomplish?					