

Patient Information

Patient Name: _____
Last First Middle (name called)
Mr. Mrs. Ms. Miss Dr. Rev. Sex: Male Female

Street Address: _____ Home Phone: _____
City, State, Zip: _____ Birthdate: _____ Age: _____

Dentist name: _____
Physician name: _____
Who referred you to our office? _____

FOR ADULT PATIENTS ONLY: Work Phone: _____ Cell Phone: _____
Employer: _____ Social Security number: _____

Parent/Guardian Information for patients under age 21, spouse for adult patients

Responsible party 1: _____
Last First Middle (name called)
Mr. Mrs. Ms. Miss Dr. Rev. Relationship: _____

Social Security # _____ Birthdate: _____

Street Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Cell Phone: _____

Employer: _____

Responsible party 2: _____
Last First Middle (name called)
Mr. Mrs. Ms. Miss Dr. Rev. Relationship: _____

Social Security # _____ Birthdate: _____

Street Address: _____ Home Phone: _____
City, State, Zip: _____ Work Phone: _____
Cell Phone: _____

Employer: _____

Primary Orthodontic Insurance

Secondary Orthodontic Insurance

Name of Insured: _____

Name of Insured: _____

Insurance Company: _____

Insurance Company: _____

Group Number: _____

Group Number: _____

Lifetime max: _____

Lifetime max: _____

Medical History

- Are you allergic to any medicines? Yes No
- Are you allergic to any cosmetics? Yes No
- Are you allergic to nickel or other metals? Yes No
- Are you allergic to latex rubber? Yes No
- Any other allergies? Yes No
- Are you currently under a physician's care? Yes No
- Are you currently taking any medications? Yes No
- Were you ever in the hospital? Yes No
- Have you had bleeding that would not stop? Yes No
- Have you had seizures? Yes No

Please explain any "yes" answers or any other general health concerns:

Dental History

- Have you had any injuries to the mouth/ teeth? Yes No
- Is there a thumb or finger habit? Yes No
- Are there any missing or extra teeth? Yes No
- Is there popping/soreness of the jaw joint/TMJ? Yes No
- Have you consulted an orthodontist before? Yes No

Date of your last dental cleaning_____

If yes give explanation: _____

What concerns about the patient's teeth have made you seek orthodontic treatment?

I verify that the above information is true to the best of my knowledge.

Signature_____ Date_____

Medical/Dental history updates (inform us of any future changes):

Changes_____

Signature_____ Date_____

Changes_____

Signature_____ Date_____