Patient Information

* Patient Name: (Required)

Gender: ○ Male ○ Female

Home Address:

City:

State:

Zip:

Employer's Name:

Occupation:

Social Security Number:

Birth Date:

Age:

Primary Phone Number:

Phone Type ○ Home ○ Cell

OK to leave message? ○ Yes ○ No

E-mail:

Spouse / Partner Information

Spouse/Partner's Name:

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Significant Other

Address (if different than patient):

City:

State:

Zip:

Social Security Number:

Birth Date:

Driver's License Number:

Primary Phone:

Phone Type: ○ Home ○ Cell

Secondary Phone:

Phone Type: ○ Home ○ Cell

Emergency Contact Information

Emergency Contact's Name:

Phone Number:

Relation to Patient:

Person(s) OK to release appointment or medically-related information to:

Relation to Patient:

Address:

City:

State:

Zip:

Insurance Information

Primary Insurance

Primary Insurance Company:

Phone Number:

Group Number:

Policy Number:

Member ID Number:

Co-pay (if known):

Deductible (if known):

Policy Holder's Name:

Relation to Patient:

Policy Holder's SSN:

Policy Holder's Date of Birth:

Employer:

Work Phone Number:

Secondary Insurance

Secondary Insurance Company:

Phone Number:

Group Number:

Policy Number:

Member ID Number:

Co-pay (if known):

Deductible (if known):

Policy Holder's Name:

Relation to Patient:

Policy Holder's SSN:

Policy Holder's Date of Birth:

Employer:

Work Phone Number:

Dental History

General Dentist:

Last Visit:

How did you hear about our practice? ☐ Ad ☐ Internet ☐ Family/Friend ☐ Physician ☐ Other

Name of person referring (if applicable):

What are the main concerns you would like orthodontics to correct?

Have you visited an orthodontist before? ○ Yes ○ No

If yes, when:

Reason:

Have your tonsils or adenoids been removed? ○ Yes ○ No

Have you ever experienced jaw joint pain/discomfort (TMJ/TMD)? ○ Yes ○ No

Do you have any missing or extra permanent teeth? ○ Yes ○ No

Have you ever had an injury to (select all that apply): ☐ Teeth ☐ Mouth ☐ Chin

Do you have speech problems? ○ Yes ○ No

If so, explain:

Do your gums bleed? ○ Yes ○ No

Do you smoke? ○ Yes ○ No

Do you like your smile? ○ Yes ○ No

Do you currently or have you ever had any of the following habits (check all that apply):
☐ Clenching/Grinding Teeth ☐ Lip Sucking/Biting ☐ Mouth Breathing ☐ Nail Biting
☐ Thumb/Finger Sucking ☐ Chewing/Eating Problem

Medical History

Are you currently being treated by a physician? ○ Yes ○ No

Reason:

Physician:

Last Visit:

Phone:

Do you have any allergies/sensitivities to medications or latex? ○ Yes ○ No

If yes, please list:

Are you currently taking any prescription or over-the-counter medications? ○ Yes ○ No

If yes, please list with the dosage:

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)?
○ Yes ○ No

Have you had any serious illnesses or operations? If yes, describe:

Have you ever had a blood transfusion? ○ Yes ○ No

If yes, give approximate dates:

(Women) Are you pregnant? ○ Yes ○ No

Nursing? ○ Yes ○ No

Taking birth control pills? ○ Yes ○ No

Check if you have ever had any of the following:
☐ Anemia ☐ Arthritis, Rheumatism ☐ Artificial Heart Valves ☐ Artificial Joints ☐ Asthma
☐ Back Problems ☐ Blood Disease ☐ Cancer ☐ Chemical Dependency ☐ Chemotherapy
☐ Circulatory Problems ☐ Cortisone Treatments ☐ Cough, Persistent ☐ Coughing Blood
☐ Diabetes ☐ Epilepsy ☐ Fainting ☐ Glaucoma ☐ Headaches ☐ Heart Murmur ☐ Heart Problems
☐ Hemophilia ☐ Hepatitis ☐ High Blood Pressure ☐ HIV/AIDS ☐ Jaw Pain ☐ Kidney Disease
☐ Liver Disease ☐ Mitral Valve Prolapse ☐ Pacemaker ☐ Radiation Treatment
☐ Respiratory Disease ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Shortness Of Breath ☐ Skin Rash
☐ Stroke ☐ Swelling Of Feet Or Ankles ☐ Thyroid Problems ☐ Tobacco Habit ☐ Tonsilitis
☐ Tuberculosis ☐ Ulcer ☐ Venereal Disease (STD)

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.

I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.

I understand that where appropriate, credit bureau reports may be obtained.

Submitted by:	
Date:	