A B C

Patient Information

Patient's Name_____ Date_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Cell Phone_____

If patient is a minor, give parent's or guardian's name_____

Whom may we thank for referring you to our office?_____

Responsible Party Information

Name_____ M S D W
Last First Middle Marital Status (Circle one)

Address_____
Street City State Zip Code

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Birthdate_____ Relationship to patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Birthdate_____ Cell Phone_____

Insurance Information

Insured's name_____ ID #_____

Insurance Company_____ Group No._____ Insured's birth date._____

Insurance Co. Address_____ Phone #_____

Do you have dual coverage? Yes ☐ No ☐

Insured's Name_____ ID #_____

Insurance Company_____ Group No._____ Insured's birth date._____

Insurance Co. Address_____ Phone #_____

Emergency Information

Name of nearest relative not living with you_____

Address_____ Phone_____

(OVER)

MEDICAL HISTORY

Patient's Physician_____ Last Medical Exam_____

Address_____ Phone Number_____

Is the patient's general health good? □ Yes □ No Reason:_____

Currently taking any medications? □ Yes □ No List:_____

Any major or unusual illnesses? □ Yes □ No Explain:_____

Is patient being treated by a physician now? □ Yes □ No Reason:_____

Is patient allergic to: □ Penicillin □ Codeine □ Local anesthetic injections □ Other

Has the patient ever been diagnosed or treated for any of the following?

□ Heart disease	□ Stomach problems	□ AIDS	□ HIV Positive
□ Abnormal blood pressure	□ Frequent Headaches	□ Anemia	□ Bleeding Problems
□ Sinus trouble or hay fever	□ Cancer or Leukemia	□ Arthritis	□ Rheumatic
□ Hepatitis or liver problems	□ Congenital Heart lesions	□ Prolonged bleeding	□ Heart murmur
□ Asthma/breathing Problems	□ Herpes	□ Diabetes	□ Epilepsy
□ Tuberculosis or lung disease	□ Venereal disease	□ Ulcers	□ Jaundice

If yes, please explain:_____

Taking birth control pills? □ Yes □ No Pregnant? □ Yes □ No If yes, how far along?_____

Growth information for Patients under 18 years of Age

Father's height_____ Mother's height_____ Adopted? □ Yes □ No

Has Puberty begun? □ Yes □ No Has menstruation begun? (Girls) □ Yes □ No

School_____ Grade_____ Hobbies_____

List brothers / sisters with age:_____

Have siblings or parents had orthodontic treatment? □ Yes □ No

DENTAL HISTORY

General Dentist_____ Last Visit Date_____

Has the patient had, or have you noticed any of the following?

□ Traumatic injury to teeth, mouth, or face	□ Clenching or grinding of teeth
□ Tonsils or adenoids removed	□ missing or additional teeth
□ Pain or tenderness in jaw joint, ear, side of face	□ Nail biting
□ Thumb/finger sucking	□ Mouth breathing
□ Clicking, locking or popping of jaw joint	□ Teeth sensitive to hot, cold, sweets or pressure

If yes, explain_____

Has the patient ever been evaluated for orthodontic treatment?_____

Has the patient ever had orthodontic treatment?_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Signature (parent's signature if minor)_____ Date_____

Doctor signature_____