WELCOME

Date:

Patient Information

Patient's Name: _____
Last First Middle

Address _____
Street City State Zip

Home#_____ Cell#_____ Birthdate_____ Soc.Sec._____

Patient's Dentist_____ Family Physician_____

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

Whom may we thank for referring you?_____

Responsible Party Information

Name: _____
Last First Middle

Relationship to Patient_____

Address _____
Street City State Zip

Home Phone_____ Cell Phone_____ WorkPhone _____

Email Address_____ Soc.Sec. #_____ Birth date_____

Employer _____ Occupation_____ No. Years Employed_____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. /ID_____ Insured's Birth date_____

Insurance Company_____ Group No._____ Phone No._____

Insurance Co. Address_____ Insured's Employer_____

2nd Responsible Party

Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Email Address_____ Soc.Sec. #_____ Birth date_____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. /ID_____ Insured's Birth date_____

Insurance Company_____ Group No._____ Phone No._____

Insurance Co. Address_____ Insured's Employer_____

Dental History

Does the patient need to be pre-medicated for dental treatment due to a medical condition? Yes No

Has there been any injury to the face, mouth, or teeth? Yes No

Has the patient ever sucked a thumb or fingers? Until what age?_____ Yes No

Does the patient have any speech problems?_____ Yes No

Is the patient a mouth breather? While awake? Yes No

While sleep? Yes No

Have you been informed of any missing or extra permanent teeth? Yes No

Are there any medical, dental, or surgical problems not covered above?_____ Yes No

Has an orthodontist been consulted previously? _____ Yes No

List any musical instruments played?_____ Yes No

Reason for consultation_____

Medical History

Is patient in good health?_____ Yes No

Does the patient have any history of major illness?_____ Yes No

Has the patient ever been under the care of a physician for illness?_____ Yes No

Please list any allergies or medications_____ **LATEX: YES NO**

Check any of the following for which the patient has been treated:

Diabetes	☐	Tuberculosis	☐	Endocrine Problems	☐
Pneumonia	☐	Anemia	☐	Prolonged Bleeding	☐
Heart Trouble	☐	Epilepsy	☐	Fainting & Dizziness	☐
Rheumatic Fever	☐	Asthma	☐	Nervous Disorders	☐
Bone Disorders	☐	Kidney Involvement	☐	Liver Involvement	☐
High Blood Pressure	☐	Hepatitis	☐	Venereal Disease	☐
Blood Transfusion	☐	Emotional Problems	☐	HIV Positive/AIDS	☐
Tendency to colds	☐	Sore Throats	☐	Ear Infections	☐

Have tonsils and adenoids been removed? What age?_____ Yes No

List any drugs or medications currently being taken. Give reasons:_____

_____

Emergency Information

Name of nearest relative not living with you._____

Complete Address_____

Phone_____

Consent for Initial Consultation

I hereby give consent to an oral examination for purpose of orthodontic evaluation and a preliminary diagnosis.

SIGNATURE (Parent's signature if minor):_____DATE:_____