

First Name:

Last name:



Nickname: \_\_\_\_\_  
 Patient's Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Email: \_\_\_\_\_  
 School/Employer: \_\_\_\_\_ Grade/Position: \_\_\_\_\_  
 Interests/Sports: \_\_\_\_\_

**Primary**

Mother  Father  Step Parent  Self  Other (specify): \_\_\_\_\_

Responsible party: \_\_\_\_\_ Telephone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer/address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

**Secondary**

Mother  Father  Step Parent  Self  Other (specify): \_\_\_\_\_

Responsible party: \_\_\_\_\_ Telephone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer/address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_

How did you hear about us?  Dentist  Patient  Relative  Friend  Other: \_\_\_\_\_  
 Whom may we thank for referring you to us? \_\_\_\_\_ Present Dentist: \_\_\_\_\_  
 Reason for consultation: \_\_\_\_\_

*Circle Yes or No for which the patient has a history:*

Aids	Y N	Cancer	Y N	Drug Allergies	Y N	Immune Problems	Y N	Periodontal Disease	Y N	TMJ Problems	Y N
Allergies	Y N	Cerebral Palsy	Y N	Endocrine Problems	Y N	Kidney Problems	Y N	Pneumonia	Y N	Tooth Problems	Y N
Anemia	Y N	Chest	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Pregnant	Y N	Tuberculosis	Y N
Arthritis	Y N	Chronic Neck Pain	Y N	Fainting, Dizziness	Y N	Mouth Breathing	Y N	Prolonged Bleeding	Y N	Venereal Disease	Y N
Asthma	Y N	Clicking of Jaw	Y N	Glaucoma	Y N	Muscular Disorder	Y N	Rheumatic Fever	Y N	Diet Pill Usage	Y N
Autoimmune	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorder	Y N	Scoliosis	Y N	ADD/ADHD	Y N
Bone Disorder	Y N	Diabetes	Y N	Heart Condition	Y N	Organ Transplant	Y N	Seizures	Y N	Smoking/Tobacco	Y N
Bulimia	Y N	Down's Syndrome	Y N	High Blood Pressure	Y N	Painful Chewing	Y N	Speech Problems	Y N		

Any diseases, problems, or allergies not mentioned above? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Has the patient (child) reached puberty? For Girls- has menstruation started?  Yes  No For Boys-has voice changed?  Yes  No

Have wisdom teeth been removed? \_\_\_\_\_ Any face, mouth or teeth injuries? \_\_\_\_\_

Does the patient normally breathe through the mouth while awake or asleep? \_\_\_\_\_ Do gums bleed? \_\_\_\_\_

When was your last dental cleaning and check-up? \_\_\_\_\_ Have you ever had previous orthodontic treatment? \_\_\_\_\_

Are there any missing or extra teeth? \_\_\_\_\_ Any oral habits such as thumb-sucking or nail-biting? \_\_\_\_\_

**Insurance Information** (Please fill out completely so we may properly file your insurance)

Name of primary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Name of policy holder: \_\_\_\_\_  Mother  Father  Step Parent  self  other (specify) \_\_\_\_\_  
 Policy Owner's Employer: \_\_\_\_\_ Policy Holder's Birthdate: \_\_\_\_\_

Name of secondary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Name of policy holder: \_\_\_\_\_  Mother  Father  Step Parent  self  other (specify) \_\_\_\_\_  
 Policy Owner's Employer: \_\_\_\_\_ Policy Holder's Birthdate: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Relationship to the patient** \_\_\_\_\_ **Date:** \_\_\_\_\_