

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:** _____