**PATIENT INFORMATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name

 Last First Middle

Address

 Street City Zip

Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Last First Middle

Residence

 Street City Zip

Mailing Address

 Street City Zip

Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Work phone

Cell/other phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address

Relationship to Patient

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate Work Phone

**DENTAL INSURANCE INFORMATION**

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Social Security #

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local No.

Insurance Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.

Do you have dual coverage? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please complete the information below for the second insurance carrier.

Insured’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Social Security #

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local No.

Insurance Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No.

MEDICAL HISTORY

Physician Date of Last Visit

Address Phone

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication?

Yes No Are you allergic to any medication?

Yes No Do you have a history of a major illness or accident?

Yes No Have the tonsils and/or adenoids been removed? What age?

Yes No Have seen a physician in the last 12 months? Why?

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding Diabetes Hepatitis/Liver problems

Anemia Prolonged Bleeding Rheumatic Fever

Arthritis Epilepsy Tuberculosis

Asthma or Hayfever Gastrointestinal Disorders HIV / Aids

Bone Disorders Heart Problems Kidney problems

Are there any medical conditions we have not discussed that you feel we should be aware of?

# DENTAL HISTORY

General Dentist’s Name Date of last cleaning

What concerns you most about your teeth?

Yes No Are you presently in any dental pain?

Yes No Are you aware of any missing permanent teeth? Which ones?

Yes No Have there been any injuries to face, mouth, or teeth?

Yes No Do you have any type of thumb, tongue or other habit?

Yes No Are you a mouth breather?

Yes No Do you snore?

Yes No Are you aware of your jaw clicking or popping?

Yes No Do you grind your teeth?

Yes No Do you have “tension” headaches?

Yes No Have you had any previous orthodontic treatment? When and where?

Female Patients only:

Yes No Are you pregnant?

The above information is accurate to the best of my ability.

Signature: Date: