

WELCOME

*We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible.
Thank you for your cooperation.*

Patient Information - Child or Teen

Patient Name (First, Middle, Last) _____ Age _____ Birth Date _____
Nickname (if preferred) _____ Check One: _____ Male _____ Female
Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ SS# _____
Home Address (Street) _____ City, State, ZIP _____
Employer _____ Employer's Address _____
Occupation _____ How long? _____
General Dentist _____ How did you hear about our office? _____
Have we treated another member of your family? (Check one): _____ YES _____ NO If YES, Name _____
Have you visited an orthodontist before? (Check one): _____ YES _____ NO If YES, for what reason? _____
Anything you would like to discuss with the doctor in private? (Check one): _____ YES _____ NO
Email _____

Insurance Information

Marital Status (Check one): Single _____ Married _____ Widowed _____ Divorced _____ Domestic Partner _____

Primary

Insurance Company Name _____ Insurance Company Phone (____) _____ - _____
Insurance Company Address _____ Group or Plan _____
Insured's Name _____ Insured's Birthdate _____
Relationship _____ Insured's SS# _____
Insured's Employer _____ Employer's Address _____

Secondary

Insurance Company Name _____ Insurance Company Phone (____) _____ - _____
Insurance Company Address _____ Group or Plan _____
Insured's Name _____ Insured's Birthdate _____
Relationship _____ Insured's SS# _____
Insured's Employer _____ Employer's Address _____

HEALTH HISTORY (please check if patient has condition or received treatment)

- | | | |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD/Behavioral issues | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Heart Condition/Angina Murmur/Chest Pain |
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Blood Disorder/Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies (please list):

_____ | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Radiation Therapy |
| | <input type="checkbox"/> Diabetes or Hypoglycemia | <input type="checkbox"/> Hepatitis A, B, or C |
| | <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> Bone Disorder/Bisphosphonates |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints
Valves/Fever/Disease | <input type="checkbox"/> Eye/Hearing/Speech Impairment | <input type="checkbox"/> Rheumatic |
| <input type="checkbox"/> Seizures/Stroke/Epilepsy | <input type="checkbox"/> Handicapped/Disabilities | <input type="checkbox"/> Autism |
| | <input type="checkbox"/> Herpes | |

Other Condition(s) not listed _____

List any medication _____

Are you under the care of a physician at the current time, list reason _____

History of major illness? If YES, please describe _____

Currently taking medication? If YES, please list _____ Amount/Dose _____

Are you pregnant? _____

Family Physician _____ Phone (____) _____ - _____ Date of Last Visit _____

DENTAL HISTORY (please check if patient has condition or received treatment)

- | | |
|---|---|
| <input type="checkbox"/> Injury to face, mouth, or teeth | <input type="checkbox"/> Clenching/Grinding of teeth
List Day, Night, or Both _____ |
| <input type="checkbox"/> Thumb, finger, or lip sucking habit | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Mouth breathing, asleep or awake | <input type="checkbox"/> Adenoids Removed, Date of Removal:
_____ |
| <input type="checkbox"/> Tongue thrust | <input type="checkbox"/> Pain when popping, locking on opening
or closing jaw movement |
| <input type="checkbox"/> Removed tonsils
Date of Removal _____ | <input type="checkbox"/> Muscle tenderness or stiffness in jaw or neck area |
| <input type="checkbox"/> Any known missing permanent teeth | <input type="checkbox"/> Dizziness or ringing in ear |
| <input type="checkbox"/> Any known extra permanent teeth | <input type="checkbox"/> Snoring or breathing heavily when sleeping |
| <input type="checkbox"/> Teeth removed by extraction, Date: _____ | <input type="checkbox"/> Previous treatment of TMJ problems |
| <input type="checkbox"/> Musical Instrument _____ | |

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date _____