Welcome to [illegible] Dental!
We are so excited you chose *us* for
your Orthodontic needs!

Today's Date: ______________________________

Patient Name: ____
First Middle Last (Nickname)

Birthdate: _____/_____/_____ Age:___________ Male □ Female □

Appointment Reminders: Text □ Email □ Both □

Best Phone #: (_____)_______________ Email Address: ____

Address: ____

____
CITY STATE ZIP

General Dentist: _________________________________ Last Date Seen by General Dentist: _________________

Who may we thank for referring you?: ____

List family members that are currently in our practice?: ____

Has the patient had previous Orthodontic Treatment? Yes □ No □

What are your chief complaints you would like to discuss with [illegible] ?:____

____

Has the patient ever had the following medical problems?

Y N Abnormal Bleeding	**Y N** Allergies to any drugs	**Y N** Any Hospital Stays
Y N Any Operations	**Y N** Asthma	**Y N** Cancer
Y N Congenital Heart Defect	**Y N** Convulsions / Epilepsy	**Y N** Diabetes
Y N Handicaps / Disabilities	**Y N** Hearing Impairment	**Y N** Heart Murmur
Y N Hemophilia	**Y N** Hepatitis	**Y N** HIV+ / AIDS
Y N Kidney / Liver Problems	**Y N** Rheumatic / Scarlet Fever	**Y N** Tuberculosis (TB)
Y N Frequent Colds	**Y N** Frequent Sore Throats	**Y N** High/Low Blood Pressure

Please discuss any medical problems that the patient has

had:____

____

Has the patient had any injuries to the face, mouth, or teeth? Yes □ No □ If yes, please explain:________________________

Please list all drugs that the patient is currently taking: ____

Please list all drugs/materials that the patient is allergic to: ____

Has the patient ever has any pain/tenderness in his/her jaw joint (TMJ / TMD)?: Yes □ No □

Does the patient have the following habits? If yes, till what age?:____

Y N Lip Sucking / Biting **Y N** Nail Biting **Y N** Nursing Bottle Habits **Y N** Thumb / Finger Sucking

For Women: Are you pregnant? **Y N** Are you nursing? **Y N** Are you using birth control? **Y N** Has menstruation started? **Y N**

Responsible Party Information

Mother's Name: ________________________________ Birthdate: _____/_____/_____

Cell #: (_____)________________________________ Work #: (_____)________________ Ext.: ______

SS #: ____ Occupation: _____________________________

Step Mother □ Guardian □

Father's Name: ________________________________ Birthdate: _____/_____/_____

Home #: (_____)________________________________ Work #: (_____)________________ Ext.: ______

SS #: ____ Occupation: _____________________________

Step Father □ Guardian □

Parent's Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Who is financially responsible for charges?: ____

Name Relation to Patient

If different from above, Billing address: ____

____

CITY STATE ZIP

Primary Dental Insurance

Insurance Co. Name:__________________________________

Insurance Co. Address:________________________________

____

Insurance Co. Phone #: (_____)_________________________

Group # (Plan, Local, or Policy #):

____

Policy Owner's Name:

____

First Middle Last

Relationship to Patient: _______________________________

Policy Owner's Birthdate: _____/_____/_______

SS#: ____

Policy Owner's Employer: _____________________________

Orthodontic Coverage? Yes □ No □

Secondary Dental Insurance

Insurance Co. Name:__________________________________

Insurance Co. Address:________________________________

____

Insurance Co. Phone #: (_____)_________________________

Group # (Plan, Local, or Policy #):

____

Policy Owner's Name:

____

First Middle Last

Relationship to Patient: _______________________________

Policy Owner's Birthdate: _____/_____/_______

SS#: ____

Policy Owner's Employer: _____________________________

Orthodontic Coverage? Yes □ No □