



WELCOME TO OUR OFFICE!

Please fill in the appropriate information.

Date: _____

Name: _____

Nickname: _____

Address: _____

Home Phone: _____

City, State, Zip: _____

Birthdate: _____

Marital Status: Single Married Widowed

Age: _____ Sex: _____
Separated Divorced

E-Mail (for appointment reminders) _____

Employer: _____

Business Phone _____

Occupation: _____

Cell Phone: _____

SS# _____

Spouse's Name: _____

Business Phone: _____

Employer: _____

Cell Phone: _____

Occupation: _____

SS# _____

Children (give names and dates of birth) _____

Person Responsible for Account: _____ SS# _____

(If different than above information)

Do you have Dental / Orthodontic insurance? Yes No

If yes, please complete the insurance information form to assist in the verification benefits.

Do you use a Reimbursement Account? Yes No (Flex Plan, Cafeteria Plan)

Patient's General Dentist: _____ Dentist's Phone : _____

Patient's Physician: _____ Physician's Phone: _____

Whom may we thank for referring you? _____

Relatives treated here: _____

Has there been any previous orthodontic consultation or treatment? _____

Chief reason treatment is being sought? _____

DENTAL HISTORY		Yes	No	MEDICAL HISTORY (√ check which apply)				
Has patient ever sucked his or her thumb or fingers?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	Anemia..... <input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>
Does patient breathe through the mouth more than through the nose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	Hepatitis..... <input type="checkbox"/>	HIV positive or AIDS	<input type="checkbox"/>
Have you been informed of any missing permanent teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems..	<input type="checkbox"/>	Allergies..... <input type="checkbox"/>	Asthma/hay fever	<input type="checkbox"/>
Have you been informed of any extra teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever.....	<input type="checkbox"/>	Diabetes..... <input type="checkbox"/>	Tonsils/adenoids removed..	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any teeth been injured due to accidents or falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged bleeding. <input type="checkbox"/>	Pregnant <input type="checkbox"/>	Wear contact lenses	<input type="checkbox"/>
Has the patient had any severe head or facial injuries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness. <input type="checkbox"/>	Epilepsy	Frequent canker sores or	<input type="checkbox"/>
Is the patient especially apprehensive toward dental visits?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergy..... <input type="checkbox"/>	or fever blister	<input type="checkbox"/>
Does the patient have a history of pain, clicking or popping of jaw joint? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NONE APPLY <input type="checkbox"/>				

Other serious illnesses (specify): _____

List any drugs or medications now being taken: _____

▶ I certify that the information provided on this form is correct to the best of my knowledge.

▶ I consent to the taking of diagnostic radiographs, photographs, and study models before, during and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.

▶ I authorize release of any information including diagnosis and record of any treatment of the above named patient to third party payors and/or health practitioners.

▶ I authorize and request my insurance company (if applicable) to pay directly to the office any insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be financially responsible for payment of all services rendered on my behalf.

_____ RESPONSIBLE PARTY (LEGAL GUARDIAN) _____ DATE _____