PATIENT INFORMATION

Last Name: .....

First Name: .....

Birth Date: ..... ☐ M ☐ F

Address: .....

City/State/Zip: .....

Phone (Cell): .....

Phone (Home): .....

Email Address: .....

RESPONSIBLE PARTY

Last Name: .....

First Name: .....

Social Security No: .....

Birth Date: .....

Work Phone: .....

Employer: .....

Spouse's Name: .....

DENTAL HEALTH

Name of Dentist: .....

Phone : .....

Date of Last Visit: .....

When were you last given dental x-ray? .....

Any pain or clicking when opening mouth? .....

Have you ever had any injuries to the mouth/jaw area? .....

If yes, please explain: .....

If patient is a child: ☐ Thumb sucking ☐ Tongue Thrusting ☐ Mouth Breathing

DENTAL INSURANCE INFORMATION

Please provide Primary Subscriber information below: ☐ N/A

Last Name: .....

First Name: .....

Subscriber ID / SSN: .....

Birth Date: .....

Insurance Company: .....

Group No / Plan no.: .....

Employer: .....

HEALTH QUESTIONAIRE

Name of Physician: .....

City: .....

Are you allergic to the following:

☐ N/A ☐ Penicillin ☐ Codeine ☐ Local Anesthetics

Are you pregnant? ☐ N/A ☐ Yes ☐ No If yes, How many months? .....

Have you been hospitalized in the last two years? ☐ Yes ☐ No

If yes, explain: .....

List any other medical conditions you feel the doctor should be aware of:

.....

Have you had the following:
Please check one box for each item below.

	YES	NO		YES	NO
Anemia	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Jaw/TMJ Pain/TMD	☐	☐
Cancer/Tumors	☐	☐	Kidney Diseases	☐	☐
Diabetes	☐	☐	Skin Problems	☐	☐
Seizures	☐	☐	Rheumatic Fever	☐	☐
Fainting/Dizziness	☐	☐	Radiation Treatment	☐	☐
Growth Problems	☐	☐	Liver Disease/Hepatitis	☐	☐
Heart Problem/Disease	☐	☐	Speech Difficulties	☐	☐
Heart Murmur	☐	☐	Bisphosphate	☐	☐

OTHER DENTAL COVERAGE

Please provide Primary Subscriber information, if applicable: ☐ N/A

Last Name: .....

First Name: .....

Subscriber ID / SSN: .....

Birth Date: .....

Insurance Company: .....

Group No. / Plan No.: .....

Employer: .....

ACKNOWLEDGEMENT

I have read and understood the questions above. I hereby certify the information provided is complete and accurate to the best of my knowledge. Should there be any changes to my personal information, dental and medical health, I will notify my orthodontist.

I authorize the release information regarding my orthodontic treatment to my dental and/or medical insurance company.

I understand that where appropriate, credit bureau reports may be obtained.

.....
Signature of Responsible Party

....
Relationship to Patient **Date**

....
Doctor's Signature **Date**