# NEW PATIENT INFORMATION

Date: _______

Last name: ___________________________________ First name: ________________________________

Home Address: _______________________________ City: _________________ State: ____ ZIP: ______

Sex: _______ Age: _______ DOB: ________________ Contact Email: _____________________________

Home PH: ________________ Cell PH: ____________________ Work PH: ________________________

(Father _ Mother _ Self _)

If Patient is under 18 years of age, parental information is required

Mother's Name: _______________________________ Father's Name: _____________________________

Mother's Employer: ____________________________ Father's Employer: __________________________

Mother's Occupation: ___________________________ Father's Occupation: ________________________

Person(s) responsible for financial account and appointments: _____________________________________

## Orthodontic Insurance Information

Orthodontic Insurance: Father _____ Mother _____ Self _____ Spouse _____ Dual Coverage? Y N

Insured's Name: ___________________________ SSN: ___________________ DOB: ________________

Insurance Company: _______________________________________ Group # ________________________

Insured's Name: ___________________________ SSN: ___________________ DOB: ________________

Insurance Company: _______________________________________ Group # ________________________

Dentist Last Name: ______________ Dentist First Name: ___________Date of Last Dental Exam: ________

Dentist Address: _______________________________________________ Dentist PH: _______________

Referred to our office by: __________________________________________________________________

## MEDICAL HISTORY

Are you currently under a physician's care? Y/N If yes, why? _____________________________________________

Please check any of the following that apply:

| | | | |
|---|---|---|---|
| ___ Asthma | ___ Bleeding Gums | ___ Tonsils/Adenoids Removed | ___ Mouth Breather |
| ___ Diabetes | ___ Prolonged Bleeding | ___ Fainting/Dizziness | ___ Eating Disorder |
| ___ Epilepsy | ___ Kidney Problems | ___ HIV/AIDS Positive | ___ Heart Trouble |
| ___ Pregnant | ___ Psychiatric Care | ___ Hepatitis/Liver problems | ___ Bone Disorder |
| ___ Nursing | ___ Difficulty Opening Mouth | ___ Glandular Problems | ___ Eating Disorder |
| ___ Tobacco Use | ___ Pain Upon Chewing | ___ High/Low Blood Pressure | |

List any significant illness not mentioned above: _________________________________________________

Allergies: ____________________________________________________________________________

List any drugs or medications now being taken: ___________________________________________________

## DENTAL HISTORY

| | | |
|---|---|---|
| Has the patient ever sucked a thumb or finger? Until what age? ______ | Y | N |
| Does the patient have any missing permanent teeth? | Y | N |
| Have you been informed of any extra teeth? | Y | N |
| Have any teeth been injured due to an accident or fall? | Y | N |
| Is the patient especially apprehensive about this visit? | Y | N |
| Have you had any previous orthodontic consultation or treatment? | Y | N |

Briefly state your chief concern: ___________________________________________________________

Patient Signature (or Parent if minor): ______________________________________________________