

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:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bleeding Gums	<input type="checkbox"/> Tonsils/Adenoids Removed	<input type="checkbox"/> Mouth Breather
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prolonged Bleeding	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> HIV/AIDS Positive	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Hepatitis/Liver problems	<input type="checkbox"/> Bone Disorder
<input type="checkbox"/> Nursing	<input type="checkbox"/> Difficulty Opening Mouth	<input type="checkbox"/> Glandular Problems	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Tobacco Use	<input type="checkbox"/> Pain Upon Chewing	<input type="checkbox"/> 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): _____