Patient Information

Date _____

Patient's Name _____
LAST FIRST MIDDLE PREFERS TO BE CALLED

Address _____
STREET CITY STATE ZIP

Home Phone _____ Age ____ Birthdate _____ Adult Patient SSN # _____

Cell Phone _____ Cell Provider _____ Email Address _____
(for text confirmation)

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Friends or relatives treated here _____

Patient's School _____

Responsible Party Information

Name _____
LAST FIRST MIDDLE PREFERS TO BE CALLED MARITAL STATUS

Residence _____
STREET CITY STATE ZIP

Mailing Address _____
STREET CITY STATE ZIP

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
STREET CITY STATE ZIP

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
LAST FIRST MIDDLE

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Do you have dual coverage ❑ No ❑ Yes If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Phone No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Emergency Contact _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

HAS THE PATIENT EVER BEEN TREATED FOR ANY OF THE FOLLOWING

	YES	NO		YES	NO		YES	NO
DIABETES	❑	❑	*RHEUMATIC FEVER*	❑	❑	*ENDOCRINE OR THYROID*	❑	❑
PNEUMONIA	❑	❑	*HEART MURMURS*	❑	❑	*PROLONGED BLEEDING*	❑	❑
HEART TROUBLE	❑	❑	*ANY CONDITION REQUIRING*			*HEPATITIS*	❑	❑
TUBERCOLOSIS	❑	❑	*ANTIBIOTICS BEFORE DENTAL*			*VENEREAL DISEASE*	❑	❑
BONE DISORDERS	❑	❑	*PROCEDURES*	❑	❑	*AIDS OR HIV POSITIVE*	❑	❑
EPILEPSY	❑	❑	*WOMEN: ARE YOU PREGNANT*	❑	❑			

YES NO

IS THE PATIENT IN GOOD HEALTH? _____ ❑ ❑

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN, AND FOR WHAT CONDITION _____

_____

LIST ANY OTHER SERIOUS ILLNESS (PHYSICAL OR MENTAL) _____

LIST ANY ALLERGIES OR DRUG SENSITIVITY _____

HAVE TONSILS AND ADENOIDS BEEN REMOVED? WHAT AGE? _____ ❑ ❑

PATIENT'S PHYSICIAN _____ LAST SEEN _____

DENTAL HISTORY

YES NO

HAS THE PATIENT HAD ORTHODONTIC TREATMENT (BRACES)? HAPPY ❑ OR UNHAPPY ❑ WITH RESULT? ❑ ❑

HAS THE PATIENT HAD PERIODONTAL (GUM) TREATMENT? DESCRIBE TREATMENT _____ ❑ ❑

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? _____ ❑ ❑

HAS THE PATIENT EVER SUCKED A THUMB OR FINGER? UNTIL WHAT AGE?? _____ ❑ ❑

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? _____ ❑ ❑

HAS THE PATIENT HAD ANY PREVIOUS ORTHODONTIC EXAMINATIONS? _____ ❑ ❑

DOES THE PATIENT CLENCH OR GRIND HIS/HER TEETH? _____ ❑ ❑

IS THE PATIENT ESPECIALLY APPREHENSIVE TOWARD DENTAL VISITS? _____ ❑ ❑

PATIENT'S DENTIST _____ LAST SEEN _____

DENTIST'S ADDRESS AND PHONE NUMBER _____

WHAT IS YOUR CHIEF CONCERN OR REASON FOR COMING TO OUR OFFICE? _____

_____

LIST SPORTS AND INTERESTS _____

_____

OFFICE USE ONLY

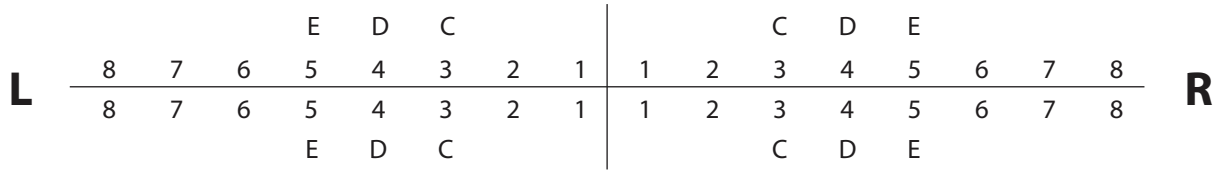
TMJ: ROM _____ R _____ L _____ O _____ P _____ Deviation _____

Clicks _____ R _____ L _____ Muscle Tenderness _____

Reducible _____

Perio _____ Gingiva _____ Habits _____

Hygiene _____ Fractures _____ Heredity _____



CL _____ ML _____ X-Bite _____

CO-OJ _____ CR-OJ _____ Slide _____

OB _____ Profile _____ Smile Line _____

Crowding: Mx _____ Mn _____

Probable · Ext _____ Non-Ext _____ Borderline _____

Treatment Time _____ Fee Range _____

Present at Exam _____

Problems _____

NT _____ Charge _____ PD _____

Date	Procedure	NT	TM	Date