

Name

First Appointment:

Nickname: _____ Email Address: _____
Patients Address: _____ Telephone: _____
Birthdate: _____ Age: _____ Sex: _____ Race: _____
School/Employer: _____ Grade/Position: _____
Interest/Sports _____

Primary

Mother Father Step Parent Self Other (specify) _____

Responsible Party: _____ Telephone: _____
Address: _____ How Long? _____
Employer/Address: _____ Telephone: _____
Social Security Number: _____ Birthdate: _____

Secondary

Mother Father Step Parent Self Other (specify) _____

Responsible Party: _____ Telephone: _____
Address: _____ How Long? _____
Employer/Address: _____ Telephone: _____
Social Security Number: _____ Birthdate: _____

How Did You Hear About Us? Dentist Patient Relative Acquaintance Other _____

Whom May We Thank For Referring You To Us? _____ Present Dentist: _____

Reason For Consultation:
Month and year of last dental cleaning? _____

Circle Yes or No for which the patient has a history:

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	Tooth Grinding	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tuberculosis	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Venereal Disease	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N		
Aspirin	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N		
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N		
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N		
Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Speech problems	Y N		
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	TMJ problems	Y N		

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Females: Have you started Menstruating? _____ At what age? _____

Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Has an orthodontist been consulted previously? _____ Have you had previous orthodontic treatment? _____

Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____

Any other questions? _____

Names and Birthdates of Siblings: _____

Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____

Policy Holders Birthdate: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____

Policy Holders Birthdate: _____

Signature: _____ Relationship To Patient: _____ Date: _____