Date _____

Confidential Patient Information

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Social Security # _____

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

Patient Age _____ Patient Birthdate _____

Confidential Responsible Party Information

Name of person responsible for account _____ Marital Status ____ Email _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Cell Phone _____ Home 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

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

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

Policy Holder's Name _____ and Soc. Sec. # _____

Insurance Company _____ Group No. _____ Union Local No. _____

Insurance Co. Address _____ Insurance Co. Phone _____

Policy Holder's Employer _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

continued on back

Patient Medical History

Please List Any Serious Recurrent Illnesses (Physical or Mental)

_____

_____

_____

_____

_____

____ Thumb Sucking
____ Mouth Breathing
____ Asthma
____ Lisping
____ Diabetes
____ Hemophilia
____ Rheumatic Fever
____ Tobacco Habit
____ Fever Blisters

Tonsils: ____ Present ____ Removed

Adenoids: ____ Present ____ Removed

Heart Murmur (if yes, diagnosed by): _____

Date diagnosed: _____

All Current Medications: _____

Allergies to Any Medications: _____

Patient Information

Patients' Physician: _____

Patients' Dentist: _____

Date of last dental cleaning: _____

Siblings' Names and Ages: _____

_____

_____

Whom may we thank for referring you to us? _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

Reason For Visit

We are interested in knowing what has brought you to our office?

_____ Overbite / Underbite
_____ Facial Profile
_____ Difficulty Eating / Speaking
_____ Crowding of Teeth
_____ Gummy Smile

_____ Dentist Referral
_____ Teeth Rotated Out of Line
_____ Prior Orthodontic Treatment
_____
_____

What is your greatest concern?

_____ Discomfort
_____ Appearance of Braces
_____ Expense
_____ None