ate ______________

onfidential 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 ______________________

onfidential 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 ______________

pouse'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 ____

o 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) ____

CONFI ENTIAL (for record and pretreatment evaluation)

ontinued on ba k

Patient Medical Hist ry

Please List Any Serious Recurrent Illnesses (Physical or Mental)

____

____

____

____

____

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

Tonsils: ____ Present
____ Removed

Adenoids: ____ Present
____ Removed

Heart Murmur (if yes, diagnosed by):
____

ate diagnosed: ________________

All Current Medications: _______________________________

Allergies to Any Medications: _______________________________

Patient Inf rmati n

Patients' Physician: _______________________________

Patients' entist: _______________________________

ate of last dental cleaning: ______________

Siblings' Names and Ages: _______________________________

____

____

Whom may we thank for referring you to us? _______________________________

Emergency Inf rmati n

Name of nearest relative not living with you _______________________________

Complete Address _______________________________

Phone ____________________ Relationship ____________________

Reas n F r Visit

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

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

_____ entist Referral
_____ Teeth Rotated Out of Line
_____ Prior Orthodontic Treatment
____
____

What is your greatest concern?
_____ iscomfort
_____ Appearance of Braces
_____ Expense
_____ None