



Date _____ **Confidential Responsible Party Information**

Name _____ Marital Status _____
Last First Middle

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 _____

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 _____

Age _____ Birthdate _____

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) _____

Patient Medical History

Please List Any Serious Recurrent Illnesses (Physical or Mental)

Thumb Sucking
 Mouth Breathing
 Asthma
 Lipping
 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 _____

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

Overbite / Underbite

Dentist Referral

What is your greatest concern?

Facial Profile

Teeth Rotated Out of Line

Discomfort

Difficulty Eating / Speaking

Prior Orthodontic Treatment

Appearance of Braces

Crowding of Teeth

Expense

Gummy Smile

None