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CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ Age: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____ Biological Sex at Birth: Female o Male o

Name & age of siblings who are current patients: _____

CONFIDENTIAL RESPONSIBLE PARTIES

Name of Primary Responsible for Account: _____ Parent O Guardian O Self O

Relation to Patient: _____ Date of Birth: _____ SS #: _____ Marital Status: _____

Address: _____

How long at this address? _____ Previous Address (if less than 3 years): _____

Primary Phone #: _____ (Home / Work / Mobile) Alt. Phone #: _____ (Home / Work / Mobile)

Email Address: _____ Occupation: _____ Driver's License #: _____

Employer: _____ No. of Years Employed: _____

Name of Secondary Responsible for Account: _____ Parent O Guardian O Self O

Relations to Patient: _____ Date of Birth: _____ SS #: _____ Marital Status: _____

Address: _____

How long at this address? _____ Previous Address (if less than 3 years): _____

Primary Phone #: _____ (Home / Work / Mobile) Alt. Phone #: _____ (Home / Work / Mobile)

Email Address: _____ Occupation: _____

Employer: _____ No. of Years Employed: _____

Emergency Contact

Name: _____ Phone #: _____ Relationship to patient: _____

PRIMARY DENTAL INSURANCE

Insured's Name: _____ SS #: _____ Employer: _____

Insurance Co.: _____ Group No.: _____ Union Local No.: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____

SECONDARY/ADDITIONAL DENTAL INSURANCE

Insured's Name: _____ SS #: _____ Employer: _____

Insurance Co.: _____ Group No.: _____ Union Local No.: _____

Insurance Co. Address: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____

I understand that where appropriate, credit bureau reports (not scores) may be obtained.

Signature (Parent's signature if minor): _____

Double T Smiles - Orthodontics

PATIENT'S PHYSICIAN(S)

Primary Physician / Pediatrician & Phone Number: _____

Specialty Care Provider(s) & Phone Number(s): _____

Dentist & Phone Number: _____ Date of Last Dental Cleaning: _____

How did you hear about us? _____

PATIENT MEDICAL QUESTIONNAIRE

Please provide an explanation for any positive (yes) responses.

YES	NO	DIAGNOSED MEDICAL CONDITIONS
		ADHD (Attention deficit hyperactivity disorder):
		Allergies to food, medicine or latex (specify):
		Asthma (triggers):
		Autism spectrum disorder:
		Anxiety / Depression:
		Bleeding Disorder:
		Bone or Skeletal Condition:
		Cancer:
		Cardiac (heart) conditions:
		Developmental Delay:
		Diabetes:
		Eczema / Skin Conditions:
		Exposure to Airborne-Transmissible Disease (eg. Tuberculosis, measles, whooping cough):
		GERD / Gastrointestinal Conditions:
		Immune Conditions:
		Kidney / Liver Conditions:
		Obstructive Sleep Apnea (OSA):
		Epilepsy / Neurologic Conditions:
		Sexual Development Disorder:
		Sickle Cell Disease, Trait:
		Thyroid Conditions:
		Other:

Please list prescribed and over-the-counter medications: _____

Please list prior surgeries/hospitalizations: _____

Tobacco use? Yes / No _____ Alcohol use? Yes / No _____

What is the reason for your visit?	√	What is your greatest concern about orthodontic treatment?	√
Overbite / Underbite / Open bite		Discomfort?	
Facial Profile		Appearance of Braces?	
Difficulty Eating / Speaking / Breathing		Expense?	
Oral Habits (thumb sucking, tongue thrust, etc.)		Other:	
Crowding / Spacing			
Gummy Smile			
Rotated Teeth			
Previous Orthodontic Treatment / Retainers			
Referred by Dentist / Physician			
Other:			

Patient or Parent/Guardian (if minor) Signature: _____ Date: _____