DATE

☐ I ACKNOWLEDGE THAT I RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES

INITIALS

PATIENT

NAME last ... first ... middle ... ◯ MALE ◯ FEMALE

DATE OF BIRTH ... SOCIAL SECURITY # ... EMAIL ADDRESS

ADDRESS ... city ... state ... zip

PHONE home ... work ... cell

WHOM CAN WE THANK FOR REFERRING YOU?

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯ friend ◯ phone book ◯ billboard ◯ newspaper ◯ dentist's office ◯ internet

GENERAL DENTIST ... LAST DENTAL VISIT

MAIN CONCERN / REASON FOR VISIT

SCHOOL (if patient is child) ... GRADE LEVEL

FAMILY

FATHER'S (or husband's) NAME ... CELL PHONE

ADDRESS (if different from patient) ... HOME PHONE (if different from patient)

EMPLOYER ... HOW LONG? ... WORK PHONE

POSITION ... EMAIL ADDRESS

MOTHER'S (or wife's) NAME ... CELL PHONE

ADDRESS (if different from patient) ... HOME PHONE (if different from patient)

EMPLOYER ... HOW LONG? ... WORK PHONE

POSITION ... EMAIL ADDRESS

RESPONSIBLE PARTY

NAME last ... first ... middle ... YEARS AT CURRENT RESIDENCE

RESIDENCE ... city ... state ... zip

MAILING ADDRESS ... city ... state ... zip

PHONE home ... work ... cell

FORMER ADDRESS (if less than 3 years in current) ... city ... state ... zip

SOCIAL SECURITY # ... DATE OF BIRTH ... RELATIONSHIP TO PATIENT

EMPLOYER ... POSITION ... NUMBER OF YEARS

ORTHODONTIC INSURANCE

INSURED'S NAME ... INSURED'S SOCIAL SECURITY #

INSURANCE COMPANY ... GROUP #

INSURED'S DATE OF BIRTH ... INSURED'S PHONE

EMERGENCY

NEAREST RELATIVE NOT LIVING WITH YOU ... RELATIONSHIP TO PATIENT ... PHONE

COMPLETE ADDRESS ... city ... state ... zip

I realize it may be appropriate to utilize a credit report in determining a payment plan.

SIGNATURE (parent signature if patient is a minor) ... DATE

UPDATES (date and initials)

NAME .... DATE ....

MEDICAL HISTORY

PHYSICIAN .... AGE AT ONSET OF PUBERTY .... FEMALES: Pregnant? Y N

MEDICATIONS ....

ALLERGIES or DRUG SENSITIVITIES? Y N If yes, explain ....

IN GOOD HEALTH? Y N If no, explain ....

ANY MAJOR ILLNESSES? Y N If yes, explain ....

Anemia	Y	N	Heart Disease/Murmur	Y	N	Frequent Colds/Sinusitis	Y	N	Tonsils Removed: Age		
Blood Disease	Y	N	Tuberculosis	Y	N	Tonsillitis	Y	N	Adenoids Removed: Age		
Diabetes	Y	N	Prolonged Bleeding	Y	N	Mouthbreathing	Y	N	Asthma	Y	N
Hepatitis	Y	N	Endocrine Problems	Y	N	Cancer / Radiation	Y	N	Artificial Joints, Valve	Y	N
Bone Disorders	Y	N	Herpes	Y	N	HIV or AIDS	Y	N	Arthritis	Y	N
Jaundice	Y	N	Epilepsy	Y	N	Osteoporosis Meds	Y	N	Rheumatic Fever	Y	N
Behavior Issues	Y	N	ADD / ADHD	Y	N	Other					

DENTAL HISTORY

SEVERE HEAD/FACE INJURIES? Y N If yes, explain ....

PREVIOUS ORTHODONTIC CONSULTATION?	Y	N	PREVIOUS ORTHODONTIC TREATMENT?	Y	N	PREVIOUS TREATMENT FOR JAW PAIN?	Y	N
PREVIOUS TREATMENT FOR HEADACHES?	Y	N	LOOSE TEETH / FOOD TRAPS?	Y	N	FAVOR ONE SIDE WHEN CHEWING?	Y	N
STRIKE SOME TEETH BEFORE OTHERS?	Y	N	SERIOUS/DIFFICULT DENTAL TREATMENT?	Y	N	TOOTH SENSITIVITY? If so, please circle 1 or more:		

OTHER ....

heat cold sweets biting pressure

JOINT HISTORY

Clenching Teeth	Y	N	Headaches	Y	N	Jaw Joint Clicking	Y	N	Grinding Teeth	Y	N
Dizziness	Y	N	Jaw Joint Soreness	Y	N	Ear Pain	Y	N	Pain Upon Opening	Y	N
Ringing in Ears	Y	N	Muscle Soreness	Y	N	Explain					

I WISH THE FOLLOWING COULD BE DONE...

STRAIGHTEN FRONT TEETH upper lower

MOVE THE UPPER TEETH forward backward

MOVE THE MIDLINE OF THE TEETH upper lower

MOVE UPPER LIP forward backward

SHOW more / less teeth / gums WHEN I SMILE

MAKE THE UPPER FRONT TEETH longer shorter

MOVE THE LOWER TEETH forward backward

MOVE CHIN forward backward to center

MOVE LOWER LIP forward backward

REDUCE STRAIN IN lips / chin WHEN CLOSING LIPS

SIGNATURE (parent signature if patient is a minor) .... **DATE** ....