Patient Information

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as you can and submit it online prior to your appointment. Thank you for your cooperation!

Date Completed

Is Patient Child or Adult? (required)

◯ Child ◯ Adult

PATIENT INFORMATION

Name Last First Middle

Address Street address Line 2

City/Town State Zip code

Birthdate Social Security # E-mail

Home Phone Sex Marital Status

General Dentist Last Visited

Whom may we thank for referring you to our office?

SPOUSE/ADDITIONAL CONTACT INFORMATION

PARENT INFORMATION

Father

Name Last First Middle

Address Street address Street Address Line 2

City/Town State Zip code

Birthdate Social Security # E-mail

Home Phone Cell Phone Work Phone

Marital Status | Relationship to Patient

Employer | Occupation | No. Years Employed

Mother

Name Last | First | Middle

Address Street address | Street Address Line 2

City/Town | State | Zip code

Birthdate | Social Security # | E-mail

Home Phone | Cell Phone | Work Phone

Marital Status | Relationship to Patient

Employer | Occupation | No. Years Employed

INSURANCE INFORMATION

POLICY OWNER INFO: Name | Social Security #

Birthdate | Relationship to Patient

Employer | Employer's Address

Ins. Company | Subscriber ID

Ins. Co. Address | Insurance Phone

SECONDARY INSURANCE?

◯ Yes ◯ No

POLICY OWNER INFO: Name | Social Security #

Birthdate | Relationship to Patient

Employer | Employer's Address

Ins. Company | Subscriber ID

Ins. Co. Address | Insurance Phone

MEDICAL/DENTAL HISTORY

Are you under the care of a physician? If Yes, explain

☐ Yes ☐ No

Physician Phone Last Visit

Address

WOMEN: Are you pregnant? ◯ Yes ◯ No If Yes, how many wks? Are you using a contraceptive? ◯ Yes ◯ No

Have you been hospitalized in last five years? If so, why?

◯ Yes ◯ No

What are the main concerns you would like orthodontics to address?

Have you been evaluated for orthodontic treatment? Have your tonsils or adenoids been removed?

◯ Yes ◯ No ◯ Yes ◯ No

Have you ever experienced jaw joint pain/discomfort?(TMJ/TMD)? Do you have any missing or extra permanent teeth? Do your gums bleed?

◯ Yes ◯ No ◯ Yes ◯ No ◯ Yes ◯ No

Have you ever had an injury to:(select all that apply): Do you smoke?

☐ Teeth ☐ Mouth ☐ Chin ◯ Yes ◯ No

Do you have speech problems? If Yes, explain Do you like your smile?

◯ Yes ◯ No ◯ Yes ◯ No

Do you have or have you ever had:

☐ Anemia ☐ Diabetes ☐ Epilepsy

☐ Hepatitis ☐ HIV ☐ Cancer

☐ Rheumatic Fever ☐ Heart Murmur ☐ ANY Heart Condition

☐ High Blood Pressure ☐ Tested for TB

Do/Have you have/had any of the following habits?

- ☐ Clenching/grinding teeth
- ☐ Lip sucking/biting
- ☐ Mouth breathing
- ☐ Nail biting
- ☐ Tongue thrusting
- ☐ Prolonged bottle/pacifier
- ☐ Thumb/finger sucking

Are you allergic/sensitive to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Tetracycline
- ☐ Erythromycin
- ☐ Penicillin
- ☐ Latex
- ☐ Anesthetics
- ☐ Other

Do you have an artificial joint or heart implant?

◯ Yes ◯ No

Have you been advised by your MD to premedicate with antibiotics for dental treatment?

◯ Yes ◯ No

Have you been tested for or told you might have heart disease?

◯ Yes ◯ No

Have you had radiation treatment for any purpose?

◯ Yes ◯ No

List all medications you are currently taking (including aspirin)

List any serious medical condition(s) treated

SIGNATURE

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.
I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.
I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form

Date

Patient's Signature (parent's signature if child)

Your patient information will be sent to us via secure server and, as always. your privacy is our office's highest priority.