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PERSONAL INFORMATION & MEDICAL HISTORY

Please fill out both front and back completely and bring it with you at the consultation appointment.
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PATIENT INFORMATION

Patient Name:

____
First Middle Last
Nickname:__________________ ☐ MALE ☐ FEMALE
DOB:__________________ AGE:__________
Home #: ______________ Cell #: ___________
Home Address:__________________ Apt#:_____
City:______________ State:_____ Zip: _______
How Long at this Address: ____________

IF PATIENT IS AN ADULT:
Work #:______________ Mobile#: __________
Employer:__________________________
How Long Employed There: ______________
SS#: _______________ DL#: __________

Responsible Party Status: ☐ Married ☐ Divorced ☐ Single
Responsible Party Email**:**____________________
Would you like to receive text messages? ☐ Yes ☐ No
If yes,What Number: __________________
Spouse Information: ☐ **N/A**
Name: ______________________________
Employer: ______________ Work#: __________

IF PATIENT IS A MINOR:
Who is with patient today?: ______________
Relation: ______________________________
Do you have legal custody of the patient? ☐ YES ☐ NO
Mother's Information:
Name: ______________ Employer: __________
Work #: ______________ Mobile #: __________
SS#: ______________ DL#: __________
Father's Information:
Name: ______________ Employer: __________
Work #: ______________ Mobile#: __________
SS#: ______________ DL#: __________

HOW DID YOU HEAR ABOUT US ?

Who may we thank for referring you? __________
Other family members seen by us: __________
____
Relation: ______________________________

DENTAL INFORMATION

Previous/Present Dentist: ______________
Address: ______________________________
Phone #: ______________ Last Visit: __________

RESPONSIBLE PARTY INFORMATION

The responsible party is the person who signs the treatment contract and is solely responsible for all aspects of the patient's account. Consequently, this is the only person with whom this office can discuss financial information unless written authorization otherwise.

Please check one if applicable:
☐ Patient (If Adult) ☐ Mother ☐ Father ☐ Other:
Relation: ______________ DOB: __________
Name: ______________________________
Billing Address: ______________________
City: ______________ State: ____ Zip: ________
How Long at this address: ______________
Employer:______________________________
How Long Employed: ________Work #: __________
Home#:______________ Mobile#: __________
SS#: ______________ DL#: __________

ORTHODONTIC INSURANCE INFORMATION

Fill Out Only If Orthodontic Benefits Available
We recommend that orthodontic benefits are confirmed with insurance co. prior to consultation appointment.

Primary Coverage:
Insurance Co. Name: ______________________
Address:______________________________
____
Phone#: ______________Group#: __________

Employee's Name: ______________________
Relationship to Patient: ________________
Employee's DOB: ______________________
Employer: ______________________________
SS#: ______________________________
Assign Benefits to: ☐ Doctor ☐ Employee

Secondary Coverage:
Insurance Co. Name: ______________________
Address: ______________________________
____
Phone#: ______________ Group#: __________

Employee's Name: ______________________
Relationship to Patient: ________________
Employee's DOB: ______________________
Employer: ______________________________
SS#: ______________________________
Assign Benefits to: ☐ Doctor ☐ Employee

DENTAL HISTORY

Why have you come to the orthodontist today? ________
____
Are you currently in pain? ☐ YES ☐ NO
Your dental health is: ☐Good ☐Fair ☐Poor
Have you ever had a serious/difficult problem associated with previous dental work? ☐ YES ☐ NO
Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? ☐ YES ☐ NO
Do you like your smile? ☐ YES ☐ NO
Do your gums ever bleed? ☐ YES ☐ NO
How many times a week do you floss? ____________
How many times a day do you brush? _____________
Types of bristles: ☐ Hard ☐ Medium ☐ Soft
Is your water fluoridated? ☐ YES ☐ NO
Are you taking fluoridated supplements? ☐ YES ☐ NO

MEDICAL HISTORY

Do you have a personal physician? ☐ YES ☐ NO
Name: ______________________________________
Phone: ____________________ Last Visit: __________
Your current personal health is:
☐ Good ☐ Fair ☐ Poor
Are you currently under the care of a doctor?
☐ YES ☐ NO Explain: ________________________
Are you taking any prescription/non-prescription drugs?
☐ YES ☐ NO List: ____________________________
____

FOR WOMEN ONLY:

Are you taking birth control pills? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO Week #: _______
Are you nursing? ☐ YES ☐ NO

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

HAVE YOU EVER HAD THE FOLLOWING DISEASES OR MEDICAL PROBLEMS ?

Y N Prothesis
Y N Heart Attack
Y N Cancer
Y N Diabetes
Y N Rheum. Fev.
Y N HIV+/AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis
Y N Shingles
Y N Fever Blister
Y N Venereal Dis.
Y N Ulcers/Colitis
Y N Heart Murm.
Y N Emphysema
Y N Sinus Probs.
Y N Other: _______
____
____

Y N History of Scarlet Fever
Y N Congenital Heart Def.
Y N Convulsions/Epilepsy
Y N Abnormal Bleeding
Y N Artificial Valves
Y N Heart Surgery/ Pacmakr.
Y N Any Stays in Hospital
Y N Kidney/Liver Problems
Y N Mitral Valve Prolapse
Y N Artificial Bones/Joints
Y N Sev./Freq. Headaches
Y N Hi/Lo Blood Pressure
Y N Drug/Alcohol Abuse
Y N Blood Transfusion
Y N Anemia/Radiation Tmt.
Y N Glaucoma
Y N Difficultly Breathing
Y N Hearing Impairment
Y N Any Operations
Y N Handicaps/Disabilities

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin
Y N Codeine
Y N Latex
Y N Other : ______
____

Y N Erythromycin
Y N Dental Anesthetics
Y N Tetracycline
Y N Penicillin

HAVE YOU EVER HAD ANY OF THE FOLLOWING HABITS?

Y N Thumb Sucking / Finger Sucking
Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing/Bottle Habits

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my / my child's medical status. Further, I give consent for insurance to be filed with assignment as indicated. I also authorize the dental staff to perform the necessary dental services I / my child may need during treatment. I understand that when appropriate a credit report may be obtained.

Signature: ______________________________________ Date: ____________________

OFFICE USE ONLY***OFFICE USE ONLY***OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.
Initials:__________ Date:__________ Doctor's Comments: ______________________________
____