Confidential Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Email Address _____

Home Phone _____ Birthdate _____ Social Security # _____

If patient is a minor, give parent or guardians' name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ _____
Last First Middle Marital Status

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 _____

Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Do you have secondary coverage? (circle one) YES NO If yes: _____

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group Number _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Insurance Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Medical Information

Heart Trouble	Y N	Tendency for Colds	Y N	Tuberculosis	Y N	Frequent Urination	Y N
Heart Murmur	Y N	Tendency for Sore Throats	Y N	Bronchitis	Y N	Jaundice	Y N
Heart Surgery	Y N	Tendency for Ear Infections	Y N	Emphysema	Y N	Diabetes	Y N
Rheumatic Fever	Y N	Tonsils and Adenoids Present	Y N	Epilepsy	Y N	Kidney Disease	Y N
Congenital Heart Defects	Y N	Removal at What Age?	____	Fainting	Y N	Liver Disease	Y N
Heart Pacemaker	Y N	Hay Fever	Y N	Ulcers	Y N	Persistent Cough	Y N
Heart Valve Prosthesis	Y N	Recurrent Illness	Y N	Stroke	Y N	Asthma	Y N
Heart Attack	Y N	Often Fatigued or Exhausted	Y N	Arthritis	Y N	Lung Disease	Y N
High Blood Pressure	Y N	Frequent Headaches	Y N	Anemia	Y N	Swollen Lymph Glands	Y N
Low Blood Pressure	Y N	Heavy Smoker	Y N	Blood Disease	Y N	Artificial Limbs	Y N
Ankles Swell	Y N	Nervous/Anxious	Y N	Glaucoma	Y N	Psychiatric Cares	Y N
Short of Breath/Mild Exertion	Y N	Depressed/Unhappy	Y N	Tumors/Growths	Y N	Venereal Disease	Y N
Chest Pains or Mild Exertion	Y N	Recent Weight Changes	Y N	Emotional Problems	Y N	Cancer Treatment	Y N
Scarlet Fever	Y N	Immune System Problems	Y N	Tension/Stress	Y N	Bulimia	Y N
Hives/Rash	Y N	HIV Positive	Y N	Thyroid Disorder	Y N	Anorexia Nervosa	Y N
Hospitalized Lately	Y N	Latex Allergy	Y N	Parathyroid Disorder	Y N	Often Thirsty	Y N

Is there any condition or problem that you think we should know about? _____

_____

Dental History

Who is your dentist? _____

Has the patient seen a general dentist in the last year	Y N	Does the patient have or ever had any of the following habits?					
Any pain, clicking or discomfort in or near the ears	Y N	Cheek, Tongue or Lip Chewing	Y N	Clenching Teeth	Y N		
Has the mouth, face or teeth been injured by a fall or accident	Y N	Thumb Sucking	Y N	Tongue Thrusting	Y N		
Have you been informed of missing or extra permanent teeth	Y N	Mouth Breathing	Y N	Grind Teeth	Y N		
Are you aware of any "gum" problems	Y N	Fingernail Biting	Y N	Speech Problems	Y N		
Are any antibiotics needed before a dental exam	Y N	Has the patient been examined by an Orthodontist before				Y N	
Is food catching or collecting between your teeth	Y N	If Yes, when? _____					
Do you feel the patient can benefit from orthodontic treatment	Y N	Have other members of the family had Orthodontic treatment				Y N	
Is the patient happy with their "SMILE"	Y N	If Yes, were you happy with the results				Y N	
Does the patient want to improve their "SMILE" or "BITE"	Y N	If No, Why? _____					
Would the patient mind wearing 'BRACES"	Y N						

In your own words, what is the orthodontic problem? _____

What would you like orthodontic treatment to accomplish? _____

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Patient Signature _____ Date _____ Parent Signature _____

For Official Use Only

			Fee	Time
		Phase I		
		Phase II		
		Partial		