Patient Information

A B C

Date ____/____/____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Phone _____ Birthdate ____/____/____ Age _____ Social Security # _____

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

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

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 _____ (Last) _____ (First) _____ (Middle) Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Co. _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____ _____ _____ _____ _____

Patient's Name _____ Nick Name _____ Sex: M ☐ F ☐

School _____ Grade _____ Interests _____

Names of children in family

_____ age: _____ _____ age: _____ _____ age: _____

_____ age: _____ _____ age: _____ _____ age: _____

General Dentist _____ Date of last dental exam _____

Referred by _____ Physician _____

MEDICAL HISTORY

Are you in good health? Yes _____ No _____ Do you have a history of a major illness? Yes _____ No _____

Please list _____

Check any of the following for which you have been treated:

_____ Diabetes	_____ Bone disorders	_____ Kidney problem	_____ Prolonged bleeding
_____ Pneumonia	_____ Anemia	_____ Tuberculosis	_____ Fainting / Dizziness
_____ Heart trouble	_____ Epilepsy	_____ Hepatitis	_____ Nervous disorders
_____ Reumatic Fever	_____ Asthma	_____ Liver involvement	_____ Other _____

_____

Have tonsils and adenoids been removed: Yes _____ No _____ At what age? _____

List any drugs or medications now being taken. Give reason: _____

_____

List any allergies or drug sensitivity: _____

DENTAL HISTORY

Yes _____ No _____ Have you had any injuries to the face, mouth, or teeth? _____

Yes _____ No _____ Have you ever sucked your finger or thumb? Until what age? _____

Yes _____ No _____ Do you have any speech problems? _____

Yes _____ No _____ Have you had speech therapy lessons? _____

Yes _____ No _____ Are you a mouth breather? While awake _____ While asleep _____

Yes _____ No _____ Have you been told of any missing or extra teeth? _____

Yes _____ No _____ Do you have sensitive teeth? _____

Yes _____ No _____ Do you grind or clench your teeth? _____

Yes _____ No _____ Do you have cracking or clicking in your jaw joint? When did it start? _____

Yes _____ No _____ Does your jaw ever lock on you? Open or closed? _____

Yes _____ No _____ Do you have headaches? How frequently? _____ Possible cause _____

Yes _____ No _____ Do you have stiff necks? How frequently? _____ Possible cause _____

Yes _____ No _____ Do you have ear aches or clogged ears? _____ Possible cause _____ Do antibiotics help? _____

Yes _____ No _____ Do your jaw muscles tire quickly while chewing? _____

Yes _____ No _____ Do you ever get knots or cramps in your jaw muscles? _____

Yes _____ No _____ Have you had previous orthodontic treatment? Orthodontist's name _____ Location _____

Yes _____ No _____ Have you consulted an orthodontist before? Orthodontist's name _____ Location _____

Yes _____ No _____ Have any of your children had orthodontic treatment? Orthodontist's name _____ Location _____

Yes _____ No _____ Has either parent had orthodontic treatment? Orthodontist's name _____ Location _____

Yes _____ No _____ Do you have friends that are present or past patients of ours? _____

Names _____

Please give your reason for the consultation: _____

_____

_____

_____