PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Patient's name: _____
Last First Middle

Address: _____
Street City Zip

Birthdate:_____ Nickname:_____ School:_____

Sports/Hobbies: _____

Parent(s) or guardian(s) name: _____

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

RESPONSIBLE PARTY INFORMATION

Name: _____
Last First Middle

Residence:_____
Street City Zip

Mailing Address: _____
Street City Zip

Home phone:_____ Work phone: _____Cell/other phone:_____

Email address:_____

Birthdate:_____ Relationship to Patient:_____

Employer:_____ Occupation:_____ No. years employed: _____

Second Responsible Party's Name:_____

Relationship to Patient: _____ Birthdate: _____Phone:_____

Employer:_____ Occupation:_____ No. years employed: _____

I authorize the following individuals to have complete access to patient records and accounts, and to make treatment decisions:

_____

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Insured's Name:_____ Insured's Birth Date: _____Relationship to Patient:_____

Group No.:_____ ID# or SS#:_____

Insurance Company:_____ Insurance Co. City & State: _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name:_____ Insured's Birth Date: _____Relationship to Patient:_____

Group No.:_____ ID# or SS#:_____

Insurance Company: _____ Insurance Co. City & State: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Complete address:_____
Street City Zip

MEDICAL HISTORY

Physician: _____ Date of Last Visit: _____
Address: _____ Phone: _____
Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist: _____ Date of last visit: _____
What is the primary concern about the patient's teeth?: _____

Yes No Is the patient presently in any dental pain? _____
Yes No Ever experienced any unfavorable reaction to dentistry? _____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to face, mouth, or teeth? _____
Yes No Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping? _____
Yes No Aware of clenching or grinding teeth during the day? _____
Yes No Experience "tension" headaches? _____
Yes No Has the patient ever experienced chronic ringing in the ears? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Height of parents? Mom:_____ Dad:_____ Unkown: _____
Yes No Are you aware that some appointments will be during school hours? _____

CONSENT

I certify that I have read and understand the above. I acknowledge that I have completed this form to the best of my knowledge, and that my questions have been answered to my satisfaction. I will not hold my orthodontist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there is any change later to this history record or medical or dental status, I will inform the practice.

Signature: _____ Date: _____