

PATIENT INFORMATION

Name: _____			Date: _____		
First	Middle	Last			
Nickname: _____	Date of Birth: _____	Age: _____	Sex: <input type="checkbox"/> Female, <input type="checkbox"/> Male		
Address: _____			Phone: _____		
			City	State	Zip
E-Mail Address: _____	Patient's Hobbies & Interests: _____				
Has any member of family undergone orthodontic treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (Name: _____)					
Do you know anyone being treated in this office? <input type="checkbox"/> No <input type="checkbox"/> Yes (Name: _____)					
Whom may we thank for referring you? _____					
Patient's Dentist: _____		Phone: _____		Address: _____	
Last Cleaning: _____					

RESPONSIBLE PARTY INFORMATION

Name: _____					
First	Middle	Last			
Relation to Patient: <input type="checkbox"/> Father; <input type="checkbox"/> Mother, <input type="checkbox"/> Spouse, <input type="checkbox"/> Self, Other: _____					
Address: _____					
City					
State					
Zip					
How long at this address: _____ years (If less than 3 years, previous address: _____)					
Annual household income: under \$30,000 \$30,001- \$40,000 \$40,001 – \$50,000 \$50,000-\$65,000 over \$65,000					
Phone: (Home): _____		Work: _____		Cell: _____	
Employer: _____		Occupation: _____		Years Employed: _____	
Social Security #: _____		Date of Birth: _____			
Dental Insurance Company: Delta; MetLife; Cigna; Aetna; Guardian; Blue Cross; Blue Shield; United Concordia; Other _____					
Insurance member service phone number _____					
Spouse Name: _____					
		First	Middle	Last	
Phone: Work: _____		Cell: _____			
Employer: _____		Occupation: _____		Years Employed: _____	
Social Security #: _____		Date of Birth: _____		Relation to Patient: _____	
Dental Insurance Company: Delta; MetLife; Cigna; Aetna; Guardian; Blue Cross; Blue Shield; United Concordia; Other _____					
Insurance member service phone number _____					

OTHER DENTAL INSURANCE INFORMATION

(If different from the above)					
Name of the Insured: _____					
Address (if different from the Patient's address) _____					
Employer Name: _____		Address: _____			
SSN#: _____		Date of Birth: _____			
Relation to Patient: Father; Mother; Other: _____					
Dental Insurance Company: Delta; MetLife; Cigna; Aetna; Guardian; Other: _____					
Insurance member service phone number: _____					
Employer: _____		Group Number: _____		Local Number: _____	

HEALTH QUESTIONNAIRE

Physician: _____ Phone: _____

Please circle yes or no

Heart Problems	Yes No	Epilepsy	Yes No	Chronic Sinus	Yes No
High Blood Pressure	Yes No	Kidney Problems	Yes No	Chronic Ear Problems	Yes No
Low Blood Pressure	Yes No	Nervous Problems	Yes No	Anemia	Yes No
Circulatory Problems	Yes No	Tuberculosis	Yes No	Arthritis	Yes No
Rheumatic Fever	Yes No	Excessive Bleeding	Yes No	Adenoids Removed	Yes No
Hepatitis	Yes No	Cerebral Palsy	Yes No	A.I.D.S	Yes No
Diabetes	Yes No	Scarlet Fever	Yes No	H.T.L.V	Yes No
Radiation Treatments	Yes No	Malignancies	Yes No	Venereal Disease/Herpes	Yes No
Any Other Complications Not Listed Above: _____					

ARE YOU ALLERGIC TO:

Penicillin yes no Codeine yes no Latex yes no
Local Anesthetics (Novocain) yes no Other: _____
Are You Pregnant? Yes No If yes, how many months? _____
Are you currently taking any medication: yes no
If yes, please list it _____
Please list any other conditions you feel the doctor should be aware of:

Have you been hospitalized in the last two years? Yes No
If yes please explain _____

DENTAL HEALTH INFORMATION:

Name of your dentist _____	Phone: _____
Address: _____	Date last seen _____
Have you had any injuries to the mouth /jaw area? Yes No	
If yes, please explain: _____	
When were your last Dental X-Rays? _____	
Is this your first orthodontic visit? Yes No	
If no, when as the last time? _____	
Has the dentist pointed to some orthodontic problem? Yes No	
If yes, please explain _____	
Do you have any pain or clicking on opening mouth? Yes No	
If yes; please explain _____	
Please list any experiences or problems you would like the doctor to be aware of _____	

Emergency Contact: _____	Phone: _____
Address: _____	

Signature of Responsible party Relationship Date

Office use only _____	
<u>Update Health History:</u>	
Parent/patient Signature _____	Date _____