



PATIENT INFORMATION

Patient Name: _____ Dentist: _____
Address: _____ Zip: _____
Telephone: _____ Cell: _____
Birthdate: _____ Age: _____ Sex: Male Female
School/Employer: _____ Grade/Position: _____
Email: _____
Reason(s) for orthodontic consultation: _____

PRIMARY

Responsible Party: _____ Telephone: _____
 Mother Father Step Parent Self Other (specify) _____
 Single Married Divorced
Address: _____ Zip: _____
Employer: _____ Telephone: _____
Social Security Number: _____ Birthdate: _____

SECONDARY

Responsible Party: _____ Telephone: _____
 Mother Father Step Parent Self Other (specify) _____
 Single Married Divorced
Address: _____ Zip: _____
Employer: _____ Telephone: _____
Social Security Number: _____ Birthdate: _____

HOW DID YOU HEAR ABOUT US? *(Please check all that apply)*

- Referral: Dentist Patient Other _____
Name of person we may thank for the referral: _____
 Community Event: _____ Sporting Event: _____ School Event: _____
 Online Print Ad: (Where?) _____
 Other family members seen by us: _____
 Has the patient had a previous orthodontic evaluation? _____

HEALTH HISTORY (Check Yes or No for which the patient has had a history)

AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest Pains	<input type="checkbox"/> Y <input type="checkbox"/> N	Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N	Painful Chewing	<input type="checkbox"/> Y <input type="checkbox"/> N
Allergic to Latex	<input type="checkbox"/> Y <input type="checkbox"/> N	Chronic Neck Pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart Condition	<input type="checkbox"/> Y <input type="checkbox"/> N	Periodontal Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Clicking of Jaw	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores/Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N	High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Prolonged Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N	Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N
Bone Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Drug Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Speech Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N	Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Mouth Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N	TMJ Problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	Fainting, Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N	Muscular Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N	Tooth Grinding	<input type="checkbox"/> Y <input type="checkbox"/> N
Cerebral Palsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Organ Transplant	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N

Any disease, problem or allergy not mentioned above? _____

Current medications? _____

Physician Name: _____ Telephone: _____

Any face, mouth or tooth injuries? _____

INSURANCE INFORMATION

Name of Primary Dental Insurance: _____

Employer: _____

Name of Policy Holder: _____

Mother Father Step Parent Self Other (specify) _____

Group #: _____ Member ID #: _____

Primary Holder's Date of Birth: _____

Name of Secondary Dental Insurance: _____

Employer: _____

Name of Policy Holder: _____

Mother Father Step Parent Self Other (specify) _____

Group #: _____ Member ID #: _____

Secondary Holder's Date of Birth: _____

Emergency Contact Name: _____

Address: _____

Daytime Telephone: _____ Evening Telephone: _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes the medical status. I authorize the dental staff to perform the necessary dental services the patient may need. I also acknowledge that I have received a copy of the Notice of Privacy Practices (from the website or from the welcome packet in the mail). This office reserves the right to verify the credit status of potential patients or responsible party/guardian of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature: _____ Relationship to patient: _____ Date: _____

You will be asked to verify and sign this form at the consultation appointment.

PRINT