



Please Complete Both Sides

New Patient Information

Patient Information

Date Patient Name Nickname SS# Address City State Zip Email Birth Date Age Gender Cell Phone Home Phone School Grade Whom may we thank for referring you to our office? Other family members seen by us General Dentist Address Siblings: Name Age Name Age Who is with the child today? Name Relationship Do you have legal custody of this child? Yes No

Responsible Party Information

Applies to Minors Only

Father's Name (or Self) Address City State Zip Email Address Cell Phone Home Phone Work Phone SS# Birth Date DL# Relationship to Patient Employer Mother's Name (or Spouse) Address City State Zip Email Address Cell Phone Home Phone Work Phone SS# Birth Date DL# Relationship to Patient Employer Person financially responsible for this account Father/Self Mother Marital Status: Single Married Divorced Widowed

Orthodontic Insurance Information

Primary Insured Name Birth Date SSN Insurance Company Group No. Employer Insurance Co. Address City State Zip Phone Do you have Dual coverage? Secondary Insured Name Birth Date SSN Insurance Company Group No. Employer Insurance Co. Address City State Zip Phone

Emergency Information

Name of nearest relative not living with you Phone Complete Address

DENTAL HISTORY

Why is the patient being seen by the Orthodontist today? _____

Has the patient ever had any pain or tenderness in the jaw joint (TMJ/TMD) Y N

Has the patient ever had a serious/difficult problem associated with dental work? Y N

Is the patient's water fluoridated? Y N

Is the patient taking fluoridated supplements? Y N

Does the patient brush teeth daily? Y N

Types of bristles? Hard Medium Soft

Floss their teeth daily? Y N

Does the patient like their smile? Y N

Does the patient's gums ever bleed? Y N

MEDICAL HISTORY

Does the patient have a personal physician? Y N

Name: _____

Phone: _____ Last visit: _____

Is the patient currently under the care of a doctor? Y N Explain: _____

Please describe the patient's health:
Good Fair Poor

Please list all drugs the patient is currently taking: _____

Does the patient have any of the following habits?

Y N Thumb Sucking/Finger Sucking

Y N Lip Sucking/Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Has the patient ever had any of the following diseases or medical problems?

Y N Prothesis	Y N History of Scarlet Fever
Y N Heart attack	Y N Congenital Heart Def.
Y N Cancer	Y N Convulsions/Epilepsy
Y N Diabetes	Y N Abnormal Bleeding
Y N Rheum. Fev.	Y N Artificial Valves
Y N HIV/AIDS	Y N Heart Surgery/Pacemkr.
Y N Hemophilia	Y N Any Stays in Hospital
Y N Asthma	Y N Kidney/Liver Problems
Y N Hepatitis	Y N Mitral Valve Prolapse
Y N Tuberculosis	Y N Artificial Bones/Joints
Y N Shingles	Y N Sev./Freq. Headaches
Y N Fever Blister	Y N Hi/Lo Blood Pressure
Y N Venereal Disease	Y N Drug/Alcohol Abuse
Y N Ulcers/Colitis	Y N Blood Transfusion
Y N Heart Murm.	Y N Anemia/Radiation Tmt.
Y N Emphysema	Y N Glaucoma
Y N Sinus Problems	Y N Difficulty Breathing
Y N Hearing Impairment	Y N Handicaps/Disabilities
Y N Other:	

Is the patient allergic to any of the following?

Y N Aspirin	Y N Erythromycin
Y N Codeine	Y N Dental Anesthetics
Y N Latex	Y N Tetracycline
Y N Penicillin	Y N Other:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

FOR WOMEN ONLY:

Are you taking birth control pills? Y N

Are you pregnant? Y N Week #: _____

Are you nursing? Y N

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or the patient) ever have any change in health status or medications being taken or if I (or the patient) have any abnormal medical test results, I will inform the dentist at the next appointment without fail. I authorize the dental staff to perform the necessary dental services the patient may need during treatment. I also authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I authorize payment of primary insurance benefits directly to the dentist otherwise payable to me. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

Signature

Date

OFFICE USE ONLY ---OFFICE USE ONLY --- OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient/guardian.

Initials: _____ Date: _____

Doctor's comments: _____

Medical History Update:

1. Date: _____ Signature: _____

Comments: _____

2. Date: _____ Signature: _____

Comments: _____