A B C

Patient Information

Date: _____ Patient's # _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Best Contact Phone _____ Birthdate _____ Social Security # _____

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

Siblings and their ages _____

If patient is an adult, names and ages of children _____

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

If a member of your family is now a patient at this office please list their name: _____

Have you or any member of you family ever been a patient in this office? Please list name: _____

Patient's Dentist _____ Date of last visit _____

Responsible Party Information

Name _____ ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____ Email: _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Best Phone _____

Orthodontic Insurance Information

PRIMARY

Insured's Name _____ DOB _____ Rel. _____

SS# _____ Employer _____

Ins. Co. Name _____ Ins. Phone _____

Address _____

SECONDARY

Insured's Name _____ DOB _____ Rel. _____

SS# _____ Employer _____

Ins. Co. Name _____ Ins. Phone _____

Address _____

For Office Use Only

Lifetime Max: _____ Pmt% _____

Ded: _____ Age Limit: _____

Eff. Date: _____ Amt Used: _____

Wait Period: _____ E-Claims: Y N

Group # _____ Payor ID: _____

Exclusions: _____

Billing : Auto_____ Bill _____

Spoke to: _____ Web / Database ___

Checked by _____ Date: _____

Other Info: _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____ Relationship _____

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

SIGNATURE (Parent's signature if minor) X _____

Empl. Initials _____ Main Concern _____

Req. Records: _____

HEALTH HISTORY

CIRCLE

1. Are you having jaw pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having ortho treatment? ..... YES NO
3. Have you been a patient in the hospital during the past two years? ..... YES NO
4. Have you been under the care of a medical doctor during the past two years? ..... YES NO

   Physician's Name: _____ Phone #: _____

   Address: _____
5. Have you taken any medicine or drugs during the past two years? ..... YES NO

   If yes, please list: _____
6. Are you now taking any medications, drugs or pills? ..... YES NO

   If yes, please list: _____
7. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? (Such as Latex or any metals) ..... YES NO

   If yes, please list: _____
8. Indicate which of the following you have had or have at present. Circle "yes" or "No" to each item.

Adenoids Removed ..... YES NO	Cosmetic Surgery ..... YES NO	Liver Disease ..... YES NO
AIDS ..... YES NO	Diabetes ..... YES NO	Metal Health Problems .... YES NO
Allergies or Hives..... YES NO	Drug Addiction ..... YES NO	Mononucleosis ..... YES NO
Anemia ..... YES NO	Emphysema ..... YES NO	Nervousness ..... YES NO
Angina Pectoris ..... YES NO	Endocrine Disorders ..... YES NO	Pain in Jaw Joints ..... YES NO
Anorexia/Bulimia ..... YES NO	Epilepsy or Seizures ..... YES NO	Pneumonia ..... YES NO
Arthritis ..... YES NO	Fainting or Dizzy Spells ..... YES NO	Polio ..... YES NO
Artificial Heart Valve ..... YES NO	Fever Blisters ..... YES NO	Pregnant ..... YES NO
Asthma ..... YES NO	Glaucoma ..... YES NO	Rheumatic Fever ..... YES NO
Attention Deficit Disorder.. YES NO	Hay Fever ..... YES NO	Rheumatism ..... YES NO
Birth Defects or	Hearing Loss ..... YES NO	Scarlet Fever ..... YES NO
Hereditary Problems ..... YES NO	Heart Pacemaker ..... YES NO	Seizures ..... YES NO
Blood Pressure High/Low YES NO	Heart Surgery ..... YES NO	Sickle Cell Disease..... YES NO
Blood Transfusion ..... YES NO	Heart Trouble ..... YES NO	Sinus Trouble ..... YES NO
Bruise Easily ..... YES NO	Hemophilia ..... YES NO	Skin Disorder ..... YES NO
Chemotherapy,	Hepatitis A (infectious) ..... YES NO	Speech Difficulties..... YES NO
(Cancer, Leukemia) ..... YES NO	Hepatitis B (Serum)..... YES NO	Stroke ..... YES NO
Cold Sores ..... YES NO	Immune System Problems . YES NO	Substance Abuse ..... YES NO
Congenital Heart lesions.. YES NO	Jaundice or Liver Problems YES NO	Thumb Sucker (Until what age?) Y/N ___
Cortisone Medicine ..... YES NO	Kidney Problems ..... YES NO	

9. Is there any information you can share that will aid us in treating you or your child?

   _____

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep? ..... YES NO
13. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Do you have any disease, condition, or problem not listed? ..... YES NO

In case of emergency, person to contact.

Name: _____ Phone: _____

Address: _____

I have read and understood the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will inform this practice.

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with _____

(Name of Patient)

and further authorize and consent that Doctor choose and employ such assistance as deemed fit. Bureau reports may be obtained.

Signature (Parent's signature if minor) _____