Patient Information **Date:_____________**

Patient's full name: ____ Prefers to be called: ______________________

Patient's Address: ____ Home Phone: ___________________________

____ Cell Phone: _____________________________

Patient's Email Address: ____

Patient's Birthday: ____________________________ Age: _______ □ Male □ Female

Patient's Dentist: ____ Favorite Hobbies: ________________________

Whom may we thank for referring you? _________________________________ School: ______________________

Names/ages of siblings: ____

Other family members seen by us: ____

Responsible Party Information

Name: _______________________________ □ Married □ Single □ Divorced SSN: ______________________

Home Address: ____ No. of years at address: ______

Home phone: ____________________ Cell phone: ______________________ Email: ____________________________

Your relationship to patient: ____________________________________ Your birthday: ________________________

Employer: ________________________ Occupation: ____________________ Work phone: ______________________

Spouse's Name: _______________________________________ Spouse's birthday: ____________________________

Spouse's Cell phone: ___________________ Email: ________________________ Spouse's SSN: __________________

Spouse's Employer: _________________ Occupation: _____________________ Work phone: ______________________

Primary Dental Insurance Information

Insured's Name: ____Insured's SSN: ___________________

Insured's Employer: ____ Insured's Birthday: __________________

Insurance Company Name: ___________________________________ Phone #: _______________________________

Insurance Company Address: ____

Group Number (Plan, local or policy No.): ____

Relationship to patient: ____

Health History

Medical History

(please check if patient has, or has had…)

- ☐ AIDS/HIV Infection
- ☐ Alcoholism
- ☐ Angina/Chest pain
- ☐ Arthritis
- ☐ Asthma/Breathing problems
- ☐ Blood disease
- ☐ Cancer/Tumors
- ☐ Cold sores
- ☐ Diabetes
- ☐ Drug addiction/use
- ☐ Emotional problems
- ☐ Endocrine problems
- ☐ Epilepsy
- ☐ Excessive bleeding
- ☐ Heart problems
- ☐ Hepatitis A, B or C
- ☐ High/Low blood pressure
- ☐ Intestinal Problems
- ☐ Joint swelling
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Lung disease
- ☐ Rheumatic Fever
- ☐ Thyroid problems
- ☐ Tonsils removed
- ☐ Tuberculosis

Please explain all checked responses: ____

List any allergies: ____

List any medications: ____

Dental History

(please check if patient has, or has had…)

- ☐ Any injuries to face, mouth or teeth?
- ☐ Thumb, finger or lip sucking habit?
  - ☐ continuing ☐ discontinued
- ☐ Mouth breathing when asleep, awake?
- ☐ Any known missing permanent teeth?
- ☐ Any known extra permanent teeth?
- ☐ Any teeth removed by extraction?
  - When? __________________
- ☐ Is there a tongue thrust problem?
- ☐ Any clenching/grinding of teeth?
  - ☐ day ☐ night ☐ both
- ☐ Any pain, popping or locking on opening or closing jaw movement?
- ☐ Frequent headaches?
- ☐ Any muscle tenderness or stiffness in jaw or neck area?
- ☐ Any ringing in ear or dizziness?
- ☐ Any previous treatment for TMJ problems?

Please explain all checked responses: ____

Please list your chief concern(s) and what you would like treatment to accomplish:

____

____

____

Has patient ever been ☐ evaluated or ☐ treated by any previous orthodontist? If yes, complete below.

Orthodontist: ____ Last seen: ___________________

Address: ____

Treatment Started: ____

SIGNATURE: _____________________________