
Patient Name_____ ❑ Male ❑ Female

Social Security #_____ Birth Date _____ Driver License # _____

Home Address_____

City _____ State_____ Zip_____

Primary Phone # _____ ❑home ❑cell Ok to leave Message? ❑Y ❑N

Secondary Phone # _____ ❑home ❑cell ❑other Ok to leave Message? ❑Y ❑N

Email Address_____

Employer's Name _____ Occupation_____

Marital Status ❑ Single ❑Married ❑ Divorced ❑ Widowed ❑ Significant Other

Spouse/Partner's Name _____

Emergency Contact Name _____

Address_____

City _____ State_____ Zip_____

Phone # _____ Relation to you _____

Person(s) OK to release appointment or medically related information to concerning you.

_____ Relation _____

Primary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

Secondary Insurance Company _____ Phone Number _____

Group # _____ Policy # _____

Policy Holder's Name _____ Relation _____

Policy Holder's Social Security #_____ Policy Holder's Birth Date _____

Employer _____ Work Phone #_____

Co-pay (if known) _____ Deductible (if known) _____

General Dentist _____ Last Visit _____

How did you hear about our Practice? ❑Ad ❑Internet ❑ Family or Friend ❑Physician ❑Other

Name of person referring (if applicable) _____

What are the main concerns you would like orthodontics to accomplish?

_____

Have you visited an orthodontist before? ❑Y ❑N

When? _____ Reason? _____

Have your tonsils or adenoids been removed? ❑Y ❑N

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD) ? ❑Y ❑N

Do you have any missing or extra permanent teeth? ❑Y ❑N

Have you ever had an injury to (*select all that apply*) : ❑Teeth ❑Mouth ❑Chin

Do you have speech problems? ❑Y ❑N If so, explain _____

Do your gums bleed? ❑Y ❑N Do you smoke? ❑Y ❑N Do you like your smile? ❑Y ❑N

Do you currently or have you ever had any of the following habits (*check all that apply*)?

❑Clenching/Grinding Teeth ❑Nail biting

❑Lip Sucking/Biting ❑Thumb/ Finger Sucking

❑Mouth Breathing ❑Chewing/Eating Problems

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Are you currently being treated by a physician? ❑Y ❑N

Physician _____ Last Visit _____ Phone _____

Reason _____

Do you have any allergies/sensitivities to medications or latex? ❑Y ❑N If yes, please list allergies.

_____

Are you currently taking any prescription or over-the-counter medications? ❑Y ❑N

Please list, with dosage. _____

Are you pregnant or nursing? ❑Y ❑N ❑N/A

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- I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my medical status.
- I hereby authorize the release of any information pertaining to my medical treatment necessary to process any insurance claims. I further authorize the application for benefits on my behalf for covered services and payment of any benefits to the office. I understand that I am responsible for any amount not covered by insurance.
- I understand that where appropriate, credit bureau reports may be obtained.

_____ _____

Patient Signature and/or Responsible Party (i.e. POA or Guarantor) Date