

WELCOME

To assist us in providing the most complete service, please provide the following information and health history.

Patient First/Last Name: _____ Preferred Name: _____

Date Of Birth: _____ Age: _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____

E-mail: _____

Mobile #: _____ Home #: _____ Work #: _____

*Dentist: _____ What is Your Biggest Concern? _____

*Who can we thank for referring you to us? _____

Describe Your Attitude Towards Treatment (Circle One):

I Want It Done Yesterday!

I'm Not Too Thrilled But I Know I Need It

I Don't Even Want To Be Here ☹️

PARENT INFORMATION (IF MINOR PATIENT)

Responsible Party's First/Last Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____ Employer: _____

Mobile #: _____ E-mail: _____

PRIMARY DENTAL INSURANCE

Orthodontic Coverage? Yes OR No If "Yes" please complete below:

Policy Holder's Name: _____ Policy Holder's Date Of Birth: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

SECONDARY DENTAL INSURANCE

Orthodontic Coverage? Yes OR No If "Yes" please complete below:

Policy Holder's Name: _____ Policy Holder's Date Of Birth: _____

Policy Holder's SS# or ID#: _____

Policy Holder's Employer: _____ Group #: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

MEDICAL HISTORY

<input type="radio"/> Yes	<input type="radio"/> No	Adenoids Removed
<input type="radio"/> Yes	<input type="radio"/> No	Anemia
<input type="radio"/> Yes	<input type="radio"/> No	Asthma
<input type="radio"/> Yes	<input type="radio"/> No	Birth Abnormalities
<input type="radio"/> Yes	<input type="radio"/> No	Bone Disorders
<input type="radio"/> Yes	<input type="radio"/> No	Diabetes
<input type="radio"/> Yes	<input type="radio"/> No	Earaches
<input type="radio"/> Yes	<input type="radio"/> No	Emotional Problems
<input type="radio"/> Yes	<input type="radio"/> No	Endocrine Problems
<input type="radio"/> Yes	<input type="radio"/> No	Epilepsy
<input type="radio"/> Yes	<input type="radio"/> No	Faintness/Dizziness
<input type="radio"/> Yes	<input type="radio"/> No	Heart Trouble
<input type="radio"/> Yes	<input type="radio"/> No	Hepatitis
<input type="radio"/> Yes	<input type="radio"/> No	Joint Swelling
<input type="radio"/> Yes	<input type="radio"/> No	Kidney or Liver Disease
<input type="radio"/> Yes	<input type="radio"/> No	Positive HIV Test
<input type="radio"/> YES	<input type="radio"/> NO	PREGNANT (NO XRAYS!)
<input type="radio"/> Yes	<input type="radio"/> No	Prolonged Bleeding
<input type="radio"/> Yes	<input type="radio"/> No	Rheumatic Fever
<input type="radio"/> Yes	<input type="radio"/> No	Sore Throats
<input type="radio"/> Yes	<input type="radio"/> No	Thyroid Problems
<input type="radio"/> Yes	<input type="radio"/> No	Tonsillitis
<input type="radio"/> Yes	<input type="radio"/> No	Tonsils Removed

List any other serious illnesses: _____

Allergies: (check all that apply)

- Latex
- Metal
- Drugs
- Local Anesthetics
- Other _____

Current Drugs/Medications: _____

Currently Under Physician's Care? Yes No

Physician _____

Reason _____

Comments _____

Do you have any history of facial trauma? (wreck, accident, sports injury, etc..)

DENTAL HISTORY

Any previous orthodontic treatment?	<input type="radio"/> Yes	<input type="radio"/> No
Any previous orthodontic consultations?	<input type="radio"/> Yes	<input type="radio"/> No
Visits the dentist regularly?	<input type="radio"/> Yes	<input type="radio"/> No
Recent Date: _____		
Any missing permanent teeth?	<input type="radio"/> Yes	<input type="radio"/> No
Any pain or clicking on opening/closing mouth?	<input type="radio"/> Yes	<input type="radio"/> No
Any speech difficulties?	<input type="radio"/> Yes	<input type="radio"/> No
Any difficulty swallowing or chewing?	<input type="radio"/> Yes	<input type="radio"/> No
Is there any tongue-thrusting issues?	<input type="radio"/> Yes	<input type="radio"/> No
Mouth-Breathing when asleep?	<input type="radio"/> Yes	<input type="radio"/> No
Mouth-Breathing when awake?	<input type="radio"/> Yes	<input type="radio"/> No
Any extra permanent teeth?	<input type="radio"/> Yes	<input type="radio"/> No
More than average amount of decay/cavities?	<input type="radio"/> Yes	<input type="radio"/> No
Any injuries to the face, mouth, or teeth?	<input type="radio"/> Yes	<input type="radio"/> No
Any gum loss/recession or bone loss?	<input type="radio"/> Yes	<input type="radio"/> No

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 confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____

Date: _____

I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductible that my insurance will not cover. I also understand that insurance pays over my treatment time and does not pay in full up front. If I change or lose my insurance during my treatment I will be responsible for any charges remaining on the account.

Signature: _____

Date: _____