WELCOME — *We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you.*

Patient Information

Patient's Name:_____ Date of Birth:_____
Last First Middle

Preferred Name:_____ Gender: M F Email:_____

Address:_____

Home Phone:_____ Cell Phone:_____ Cell Phone Carrier (if TEXT preferred):_____

Whom may we thank for referring you to our office (dentist, friend, family, internet, social media)? _____

Name of General Dentist:_____ Phone:_____ Date of Last Visit:_____

Have we treated another member of your family? YES NO If YES, Name_____

Have you visited an orthodontist before? YES NO If YES, for what reason_____

If the patient is a minor, please fill out the Responsible Party Information below.

Responsible Party Information

Name:_____ Relationship to Patient:_____
Last First Middle

Address:_____

Social Security #: _____ Date of Birth:_____ Phone:_____

Name:_____ Relationship to Patient:_____
Last First Middle

Address:_____

Social Security #:_____ Date of Birth:_____ Phone:_____

Insurance Information

Policy Holder's Name:_____ Policy ID or Soc.Sec. #:_____

Policy Holder's Employer:_____Group No.:_____

Insurance Company:_____ Insurance Co. Phone:_____

Insurance Co. Address:_____

Do you have dual coverage? Yes No If yes:

Policy Holder's Name:_____Policy ID or Soc.Sec. #:_____

Policy Holder's Employer:_____Group No.:_____

Insurance Company:_____Insurance Co. Phone:_____

Insurance Co. Address:_____

Emergency Contact

Name:_____ Phone:_____

Address:_____ Relationship:_____

Responsible Party Name_____ Signature_____

Dental and Medical History

Is patient in good health? **Circle** one: YES NO Describe: _____

Is patient taking any medications or other substances? YES NO

Please list medications/substances_____

If female, is patient pregnant or suspect of pregnancy? YES NO N/A _____

Under the care of a physician? YES NO Explain: _____

Physician name and phone number_____

History of major illness? YES NO Describe: _____

Any sensitivities or allergies? YES (local injected anesthetics, penicillin, aspirin, codeine, sulfites, other _____), NO

Have the adenoids and/or tonsils been removed? YES NO Explain: _____

Pain/tenderness/locking in the Jaw Joint (TMJ/TMD)? YES NO Explain: _____

Injuries to the face/mouth/teeth/chin? YES NO Explain: _____

Main orthodontic concern: _____

Any condition not listed that you would like the doctor to know about: _____

Has the patient had any of the following medical problems? Please **circle** YES or NO

YES NO ADD/ADHD	YES NO Cancer	YES NO Headaches (Severe/Frequent)	YES NO Pneumonia
YES NO AIDS	YES NO Cold Sores	YES NO Herpes	YES NO Psychiatric Problems
YES NO Anemia	YES NO Diabetes	YES NO Heart Murmur	YES NO Radiation Therapy
YES NO Angina	YES NO Dizzy Spells	YES NO Heart Condition	YES NO Rheumatic/Scarlet Fever
YES NO Arthritis	YES NO Epilepsy	YES NO Kidney Problems	YES NO Tuberculosis
YES NO Asthma	YES NO Fainting	YES NO Liver Problems	YES NO Ulcers/Colitis
YES NO Blood Disorder	YES NO Fever Blisters	YES NO Low Blood Pressure	YES NO Venereal Disease
YES NO Bone Disorder	YES NO GI Disorder	YES NO Nervous Disorder	Other _____

Please Circle YES or NO to the following **habits**:

YES NO Chewing/Eating Problems	YES NO Nail biting	YES NO Teeth Clenching	YES NO Tongue/Thumb/Finger sucking
YES NO Lip biting	YES NO Pen/Pencil Biting	YES NO Teeth Grinding	
YES NO Mouth Breather	YES NO Speech Problems	YES NO Tongue Thrusting	

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my/my child's medical status.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits.

Signature _____ Date_____

Patient/Parent/Guardian Yearly Review

12 Month _____ 24 month _____ 36 month _____

Initial and Date Initial and Date Initial and Date