



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 and bring to your appointment. Thank you for your cooperation.

Patient Information - Child or Teen

Patient's Name, Nickname, Home Address, Relationship, School, etc.

Parents' Information

Marital Status: Single, Married, Widowed, Divorced, Separated, Domestic Partner

Father

Father/Step Father/Guardian Name, Address, Phone, Occupation, etc.

If you have insurance coverage for this child, please fill out.

Insurance Co. Name, Group/Plan #, SS#/ID#, Insurance Co. Phone #, Insurance Co. Address

Mother

Mother/Step Mother/Guardian Name, Address, Phone, Occupation, etc.

If you have insurance coverage for this child, please fill out.

Insurance Co. Name, Group/Plan #, SS#/ID#, Insurance Co. Phone #, Insurance Co. Address

Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? _____

Physician _____ Phone # _____

YES NO History of any major illness? If YES, please describe _____

YES NO Currently taking any medications? If YES, please list _____

YES NO Allergic to any medications? If YES, please list _____

YES NO Are you LATEX sensitive?

YES NO Are you currently taking or have been given oral or intravenous Biophosphates (i.e. Fosamax, Actonel, Boniva)?

YES NO If female, are you pregnant?

Have you been treated for any of the following?

Allergies Arthritis Asthma Blood/Bleeding Disorder High Blood Pressure

Cancer Diabetes Epilepsy Tuberculosis Heart Conditions

Hepatitis HIV/AIDS Headaches Nervous Disorder Rheumatic Fever

Are there any medical conditions that we have not discussed that we should be aware of? _____

Dental History

Dentist _____ Date of Last Visit _____

YES NO Do you require antibiotics before dental treatment? If YES, explain _____

YES NO Have there been injuries to your face, mouth or chin? If YES, explain _____

YES NO Have any teeth (including baby teeth) been extracted by a dentist?

YES NO Have tonsils and/or adenoids been removed?

YES NO Have you ever had pain/tenderness/clicking/popping in your jaw joint (TMJ/TMD)?

YES NO Have you had previous orthodontic treatment? IF YES, for what reason _____

Do/Did you have any of the following habits?

Grinding/Clenching Teeth Finger/Thumb Sucking Tongue Thrusting Lip Sucking/Biting

Chronic Mouth Breathing Speech/Tongue Problems Chewing/Eating Problems Nail Biting

What are the concerns that you would like orthodontics to accomplish? _____

Signature

I understand that the information 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 medical status.

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

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

Signature _____ Date _____

Office Use Only

I acknowledge that I have received a copy of this office's
Notice of Privacy Practices.

Patient's/Parents' Signature

Date