



**PATIENT**

Date: \_\_\_\_\_

Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Prefers to be called \_\_\_\_\_ Hobbies, activities \_\_\_\_\_

Birth Date \_\_\_\_\_ Sex (Circle one): M F

School \_\_\_\_\_ Grade \_\_\_\_\_ Email Address(s) \_\_\_\_\_

Home Address  
(Street) \_\_\_\_\_ (City, State, Zip) \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_

**PARENT/GUARDIAN**

Patient lives with (Circle all that apply): Mother Father Stepmother Stepfather Grandparent(s) Other \_\_\_\_\_

Legal guardian(s) full name(s) \_\_\_\_\_

Title (Circle One): Mr Mrs Ms Dr Other \_\_\_\_\_ Occupation \_\_\_\_\_

Email address(es) \_\_\_\_\_

Address (Street) \_\_\_\_\_ (City, State, Zip) \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_\_) \_\_\_\_\_

**DENTIST**

Patient's Dentist \_\_\_\_\_ (City, State) \_\_\_\_\_

Last Seen \_\_\_\_\_ Reason \_\_\_\_\_ Next appointment \_\_\_\_\_

Other dentists/specialists now being seen \_\_\_\_\_ Reason \_\_\_\_\_

**PHYSICIAN**

Patient's Physician \_\_\_\_\_ City, State \_\_\_\_\_

Last Seen \_\_\_\_\_ Reason \_\_\_\_\_ Most recent physical exam \_\_\_\_\_

**GENERAL INFORMATION**

What concerns you about your child's teeth? \_\_\_\_\_

Who suggested that your child might need orthodontic treatment? \_\_\_\_\_

Why did you select our office? \_\_\_\_\_

Has your child had any previous orthodontic treatment? Please describe \_\_\_\_\_

Have any other family members been treated in this office? Please name \_\_\_\_\_

Do you think that any of your work or leisure activities affect your child's teeth or jaws? Please explain \_\_\_\_\_

### FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? \_\_\_\_\_

Address \_\_\_\_\_ (City, State, Zip) \_\_\_\_\_

Home phone (\_\_\_\_\_) \_\_\_\_\_ Cell phone (\_\_\_\_\_) \_\_\_\_\_

Work phone (\_\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Social Security # \_\_\_\_\_ Employer \_\_\_\_\_

### DENTAL INSURANCE

Primary policy holder's full name \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Rel. to Patient \_\_\_\_\_

Address and phone (if not listed above) \_\_\_\_\_

(City, State, Zip) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

(City, State, Zip) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

Does this policy have orthodontic benefits? (Circle One) Yes No Don't know

### MEDICAL HISTORY

 Now or in the past, has your child ever had the following:

- |               |   |               |  |
|---------------|---|---------------|--|
| Y N Uncertain | Injuries to face, head, neck?                                 | Y N Uncertain | Heart defects, heart murmur, rheumatic heart disease?  |
| Y N Uncertain | Cancer, tumor, radiation treatment or chemotherapy?           | Y N Uncertain | Asthma?  |
| Y N Uncertain | Diabetes or low sugar?  | Y N Uncertain | Tonsil or adenoid condition?   |
| Y N Uncertain | Kidney problems?  | Y N Uncertain | Frequently breathe through mouth?  |
| Y N Uncertain | History of osteoporosis?                                      | Y N Uncertain | Have you ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?                          |
| Y N Uncertain | Gonorrhea, syphilis, herpes, sexually transmitted diseases?   | Y N Uncertain | Have you ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders? |
| Y N Uncertain | AIDS or HIV positive?   |               |  |
| Y N Uncertain | Hepatitis, jaundice, or other liver problems?                 |               |  |
| Y N Uncertain | Mental health disturbance or depression?                      |               |  |
| Y N Uncertain | Frequent headaches or migraines?                              |               |  |
| Y N Uncertain | Excessive bleeding or bruising tendency, anemia?              |               |  |
| Y N Uncertain | Chest pain, shortness of breath, tire easily, swollen ankles? |               |  |

List Any Current Medications with Dosage \_\_\_\_\_

For Females Only:

Y N Uncertain Has your child started her period?

Y N Uncertain Pregnant?

**ALLERGIES**

Please list any allergies \_\_\_\_\_

**DENTAL HISTORY (Circle All that Apply previously or currently)**

Sensitive teeth	Frequent Oral Habits (i.e. sucking finger, chewing pen, etc)
Jaw fracture	Tooth Grinding
Cold sores	Jaw Locking
Speech problems	TMJ/Joint Treatment
Difficulty breathing through nose	Bleeding Gums
Mouth Breathing	

How often does your child brush his/her teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

**RELEASE AND WAIVER**

I authorize release of any information regarding my orthodontic treatment to my dental and/or medical insurance company.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

I have read the above questions and understand them. I will not hold my orthodontist or any member of her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my medical or dental health.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date