

Patient Information

Today's Date _____
 Male Female

Name _____
 First MI Last

Preferred Name _____

Date of Birth _____ Age _____

Medical/Dental History

Primary Dentist _____

Primary Care Physician _____

Are you taking any
 Prescription medication? Yes No

If so, which ones _____

Are you currently taking a bisphosphonate for osteoporosis?
 Yes No

List any drug sensitivities _____

Please check all that apply:

- Asthma Jaw Joint Pain Teeth Grinding
 Diabetes Bone Disorders Heart Condition
 Epilepsy ADD/ADHD AIDS/HIV
 Hepatitis Other _____

Have you been informed of any missing/extra teeth? Yes No

Has an orthodontist previously been consulted? Yes No

Previous orthodontic treatment? Yes No

Thumb sucking habit or tongue thrust? Yes No

Child Patients Only

School _____

Child's hobbies/interests _____

Is the patient adopted? Yes No

Boy: Has his voice changed? Yes No

Girl: Has she started menstruation? Yes No

If yes, Month/Year _____

Who does he/she live with?

- Both Parents Together Both Parents Separately Mother Father Other

Responsible Party Information

Name _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

Email _____

- Married Divorced Separated
 Single Widowed

Spouse/Other _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

Are there any other children that you would like us to
 evaluate? Yes No

Family Members previously seen:

Who may we thank for referring you to our office?

Insurance (if not previously give to us)

Primary Dental Insurance

Insurance Company _____

Group Number _____

Insured's Name _____

Relationship to Patient _____

Date of Birth _____ ID/SS# _____

Secondary Dental Insurance

Insurance Company _____

Group Number _____

Insured's Name _____

Relationship to Patient _____

Date of Birth _____ ID/SS# _____

X _____

Parent/Guardian Signature