Confidential Patient Information

*First Name: | Middle Initial: | *Last Name:

Nickname: | *Birthdate: | *Gender:

*Address:

*City: | *State: | *Zip:

*Main Phone: | 2nd/Cell Phone: | Email:

Social Security #:

Please list the names of any friends or family currently in the practice:

List any sports, hobbies, or musical instruments played:

Whom may we thank for referring you to our practice?

Financial Party Information

☐ Check if the patient is also the person who will be financially responsible for treatment.

*First Name: | Middle Initial: | *Last Name:

*Birthdate: | Relationship to Patient: | Email:

*Address:

*City: | *State: | *Zip:

*Main Phone: | 2nd/Cell Phone: | Social Security #:

Employer: | Occupation: | Length of Employment:

Work Phone #:

If the patient is covered by insurance, please fill out the following information. Otherwise continue down to Dental History. * ○ Yes ○ No

Policy Holder's Name: | Policy Holder's Birthdate: | Relationship to Patient:

Insurance Company: | Subscriber ID #: | Group No.:

Insurance Co. Address:

City: | State: | Zip:

Insurance Co. Phone No.:

Policy Holder's Employer:

Do you have dual dental coverage?

No Yes

(If yes, complete information below)

Policy Holder's Name:

Policy Holder's Birthdate:

Relationship to Patient:

Insurance Company:

Subscriber ID #:

Group #:

Insurance Co. Address:

City:

State:

Zip:

Insurance Co. Phone No.:

Policy Holder's Employer:

Dental History

Dentist Name:

Check-up Frequency:

Last Dental Visit:

Has the patient had an orthodontic consult or treatment?

No Yes

If so, when?

What is the patient's main orthodontic concern?

Please select YES or No for the Following Questions - Do Not Leave Blank

Speech problems/therapy?	No Yes	Grind or clench teeth?	No Yes
Oral habits (thumb/finger sucking, lip/nail biting)?	No Yes	Injury to face, jaw, teeth or mouth?	No Yes
Discomfort from teeth or gums?	No Yes	Pain, tenderness or noise in either jaw?	No Yes
Frequent headaches?	No Yes	Neck/shoulder pain?	No Yes
Frequent sore throats?	No Yes	Brush teeth daily?	No Yes
Floss teeth daily?	No Yes	Fluoride treatments?	No Yes
Mouth breathing?	No Yes	Snores during sleep?	No Yes
Requires premedication?	No Yes	Any missing or extra permanent teeth?	No Yes
Apprehensive about dental care?	No Yes	Frequently Chew Gum?	No Yes

If any of the above dental questions were answered 'Yes', please explain:

Medical History

Physician Name: **Date of last Physical:** **Patient Health:**

Address:

City: **State:** **Zip:**

List any medications currently being taken by the patient:

List any drug allergies or sensitivities that the patient may have:

Please select YES or No for the Following Questions - Do Not Leave Blank

Rheumatic Fever	**No** **Yes**	**Tuberculosis/Lung Disease**	**No** **Yes**
Pneumonia	**No** **Yes**	**Liver Disease**	**No** **Yes**
Kidney Disease	**No** **Yes**	**Heart Attack/Stroke**	**No** **Yes**
Heart Disease	**No** **Yes**	**Congenital Heart Defect**	**No** **Yes**
Heart Murmur	**No** **Yes**	**Hemophilia**	**No** **Yes**
Hypertension/High Blood Pressure	**No** **Yes**	**Prolonged Bleeding/Transfusion**	**No** **Yes**
Anemia	**No** **Yes**	**HIV/AIDS**	**No** **Yes**
Hepatitis	**No** **Yes**	**Tonsils/Adenoids Removed**	**No** **Yes**
Cancer	**No** **Yes**	**Family History of Cancer**	**No** **Yes**
Received Radiation Treatment	**No** **Yes**	**Growth Problems**	**No** **Yes**
Endocrine Problems	**No** **Yes**	**Hormone Therapy**	**No** **Yes**
Latex/Metal Allergy	**No** **Yes**	**Nervous Disorders**	**No** **Yes**
Bone Disorders/Bone Loss	**No** **Yes**	**Diabetes**	**No** **Yes**
Seizures/Epilepsy	**No** **Yes**	**Handicaps/Disabilities**	**No** **Yes**
Asthma	**No** **Yes**	**Arthritis**	**No** **Yes**
Treated for Emotional Problems	**No** **Yes**	**Ever Been Hospitalized**	**No** **Yes**
Take Bisphosphonates (Fosamax, Boniva)	**No** **Yes**	**Fen-Phen**	**No** **Yes**

If any of the above medical questions were answered 'Yes' , please explain:

Patients Under 18

If patient is under the age of 18, please answer the following questions:

Please list the name and birthdate of any siblings:

Height:

Weight:

School:

Grade:

Father/Guardian 1 Name:

Mother/Guardian 2 Name:

Has patient begun puberty: ○ No ○ Yes

If patient is a girl, has menstruation begun: ○ No ○ Yes

If patient is a boy, has their voice changed or have facial hair: ○ No ○ Yes

Has the patient grown in the past year or has their shoe size changed recently: ○ No ○ Yes

Patient's interest in treatment:

Has either biological parent ever had orthodontic treatment:

Submit Clear