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Date_____

PATIENT INFORMATION

Patient's Full name_____ Date of Birth_____ Age_____ Sex_____
Address_____City/State_____Zip Code_____
Home Phone _____ Cell Phone _____ Work Phone _____ _
SSN_____-_____-_____ Email_____

Names of friends of relative who were former patients_____
Who may we thank for referring you to our office? _____

Patient's Dentist_____ **Patient's Physician**_____

INSURANCE INFORMATION

Do you have Orthodontic Insurance? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #____-___-_____
Insurance Company_____ Group #_____ Local #_____
Insurance Company Address_____
Insurance Company Phone #_____Insured's Employer_____

Do you have dual coverage? YES NO If yes, please complete the following:

Insured's Name_____ Date of Birth_____ Insured's Social Security #____-___-_____
Insurance Company_____ Group #_____ Local #_____
Insurance Company Address_____
Insurance Company Phone #_____Insured's Employer_____

DENTAL HISTORY

Does patient receive regular dental checkups? YES NO
Last dental exam_____ Last Dental X-rays_____
Has patient received any previous orthodontic consultation or treatment? _____
How often does patient brush his/her teeth? _____ Is floss used?_____ How often? _____
Does the patient currently have, or has the patient ever had any of the following?

Y	N	Periodontal disease
Y	N	Gum surgery
Y	N	Root canals, crowns or bridges
Y	N	Any clicking, popping or pain of jaw, joints (TMJ)
Y	N	Any missing or extra teeth
Y	N	Trouble chewing
Y	N	Any past facial or mouth injuries? What? _____

What are you or your dentist most concerned about? (Purpose of visit)_____

ORAL HISTORY

The following are some habits commonly found which may influence tooth position. Last info as pertains to patient:

Y	N	Thumb sucking/until age_____	Y	N	Finger sucking/ until age_____
Y	N	Nail biting	Y	N	Mouth Breather
Y	N	Grinding of Teeth			

Other habits_____

Has patient ever had any speech therapy? _____

List any musical instruments played_____

HEALTH HISTORY

Has patient been under the care of a physician during the past two years? (Other than routine checks) Y N
If yes, for what? _____
Is patient currently taking medications? _____
Is patient allergic to anything (drugs, food, pollen, etc.)_____
Does the patient currently have, or has the patient ever had any of the following?

Y	N	Tonsils Removed	Y	N	Epilepsy/Seizures	Y	N	Nasal airway problems
Y	N	Adenoids removed	Y	N	Asthma	Y	N	Sinus problems
Y	N	Heart problems	Y	N	Bleeding problems	Y	N	Speech problems
Y	N	Diabetes	Y	N	High Blood Pressure	Y	N	Arthritis
Y	N	Anemia	Y	N	Immune Disorders	Y	N	Tobacco usage
Y	N	Pneumonia	Y	N	Lung Problems	Y	N	Respiratory problems
Y	N	Hepatitis	Y	N	Tuberculosis			

Have you been diagnosed or treated for osteoporosis? Y N
If yes, have you ever taken or are you currently taking (circle):

Fosamax Didronel Boniva Actonel Reclast or a generic form of Bisphophonates

Does the patient have any special problems not listed above? _____

EMERGENCY INFORMATION

Name of emergency contact person_____
Relation_____ Phone #_____

Our Policy is to have an appointment reminder for every patient for every appointment. Please let us know which method of contact you prefer to receive your reminder and fill in the appropriate information.

☐ **Phone Call/Voicemail** _____-_____-_____

☐ **Text** _____-_____-_____

☐ **Email** _____