PATIENT INFORMATION

Date_____ Birthdate _____ Age _____ M ◯ F ◯

Patient's Name_____
Last First Middle Nickname

Address_____Phone_____
Street City State Zip

Social Security #_____School _____ Grade_____

If patient is a minor, give parent's or guardian's name_____

List the names and ages of brothers and sisters or siblings_____

How did you hear about our office or who referred you?_____

RESPONSIBLE PARTY INFORMATION

Name_____ Marital Status_____
Last First Middle

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address? _____Home Phone_____Work Phone_____

E-Mail Address _____Cell Number _____

Previous Address (if less than 3 yrs)_____Years_____
Street City State Zip at this address

Social Security #_____Birthdate_____Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Spouse's Name_____Relationship to Patient_____
Last First Middle

Mailing Address_____
Street City State Zip

Social Security #_____Birthdate_____Work Phone_____Cell Phone_____

Employer_____Occupation_____No. Years Employed_____

ORTHODONTIC INSURANCE INFORMATION

Primary Insured's Name_____ Social Security #_____

Mailing Address_____ Date of Birth _____

Insurance Company_____ Member ID No._____Group No._____

Insurance Co. Address_____ Phone_____
Street City State Zip

Insured's Employer_____Address_____

Do you have dual coverage? ☐ Yes ☐ No If yes:

Secondary Insured's Name_____ Social Security #_____

Mailing Address_____ Date of Birth _____

Insurance Company_____ Group No. _____Local No._____

Insurance Co. Address_____ Phone_____
Street City State Zip

Insured's Employer _____Address_____

EMERGENCY INFORMATION

Name of nearest relative not living with you_____Relationship_____

Residence_____Phone_____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parents signature if minor) _____

Updates (Date & Initial)_____/_____/_____/_____/_____

CONFIDENTIAL (for record and pretreatment evaluation)

Patient's Medical History

Patient's Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Are you under a physician's care now?	☐Yes	☐No	☐N/A	_____
Have you ever been hospitalized or had a major operation?	☐Yes	☐No	☐N/A	_____
Have you ever had a serious head or neck injury?	☐Yes	☐No	☐N/A	_____
Are you taking any medication, pills or perception drugs?	☐Yes	☐No	☐N/A	_____
Do you take, or have you taken. Bisphosphonate?	☐Yes	☐No	☐N/A	_____
Are you on a special diet?	☐Yes	☐No	☐N/A	_____
Do you use tobacco?	☐Yes	☐No	☐N/A	_____
Do you use controlled substances?	☐Yes	☐No	☐N/A	_____

Women: Are you ☐ Pregnant or Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal

☐ Latex ☐ Local Anesthetic ☐ Other (Please specify) _____

Do you have, or have you ever had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle :Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/ Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pace Maker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulvers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever'	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

*Condition may require medication. N/A — Not answered by patient

Have you ever had any serious illness not listed above? ☐Yes ☐NO ☐N/A If yes, please specify _____

Comments:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize to have photographs of my face, jaws and teeth taken. understand that these items will be used as a record of my care, and may be used for educational purposes. I further understand that if these items are used in any publication or as a part of a demonstration, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

_____ _____

Signature of Patient, Parent or Guardian Date