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Personal Information

PATIENT'S NAME ______ NICKNAME ______
ADDRESS ______ CITY ______ ZIP ______
HOME PHONE ______ BIRTH DATE ______ AGE ______
SCHOOL ______
HOBBIES & INTERESTS ______ MALE ☐ FEMALE ☐

PARENT'S INFORMATION:

FATHER ______ BIRTH DATE ______
ADDRESS ______
CITY ______ ZIP ______ PHONE ______
EMPLOYER ______
ADDRESS ______
CITY ______ ZIP ______ PHONE ______
OCCUPATION ______ CELL ______
SS# ______ DL# ______

MOTHER ______ BIRTH DATE ______
ADDRESS ______
CITY ______ ZIP ______ PHONE ______
EMPLOYER ______
ADDRESS ______
CITY ______ ZIP ______ PHONE ______
OCCUPATION ______ CELL ______
SS# ______ DL# ______

INSURANCE INFORMATION:

PERSON(S) FINANCIALLY RESPONSIBLE ______ PHONE ______
DO YOU HAVE DENTAL INSURANCE? ______ NAME OF COMPANY ______
INSURED SOCIAL SECURITY # ______ **INSURED BIRTHDATE** ______
WHO MAY WE THANK FOR REFERRING YOU? ______

MEDICAL HISTORY:

DENTIST ______ PHYSICIAN ______ ORAL SURGEON ______

	YES	NO		YES	NO		YES	NO
DIABETES	☐	☐	***ANEMIA***	☐	☐	***PROLONGED BLEEDING***	☐	☐
PNEUMONIA	☐	☐	***EPILEPSY***	☐	☐	***FAINTING / DIZZINESS***	☐	☐
HEART TROUBLE	☐	☐	***ASTHMA***	☐	☐	***NERVOUS DISORDERS***	☐	☐
RHEUMATIC FEVER	☐	☐	***KIDNEY INVOLVEMENT***	☐	☐	***LIVER INVOLVEMENT***	☐	☐
BONE DISORDERS	☐	☐	***TUBERCULOSIS***	☐	☐	***ENDOCRINE PROBLEMS***	☐	☐
HEPATITIS	☐	☐	***GLAUCOMA***	☐	☐	***HIV / AIDS***	☐	☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES ☐ NO ☐ AT WHAT AGE? ______
LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASONS: ______
______
LIST ANY ALLERGIES OR DRUG SENSITIVITY: ______

DENTAL HISTORY:

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ______ YES ☐ NO ☐
HAS THE PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? ______ YES ☐ NO ☐
DOES THE PATIENT HAVE ANY SPEECH PROBLEMS? ______ YES ☐ NO ☐
IS THE PATIENT A MOUTH BREATHER: WHILE AWAKE? ______ YES ☐ NO ☐
WHILE ASLEEP? ______ YES ☐ NO ☐
HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ______ YES ☐ NO ☐
HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ______ YES ☐ NO ☐
HAS EITHER PARENT HAD PREVIOUS ORTHODONTIC TREATMENT? ______ YES ☐ NO ☐
DATE OF LAST DENTAL EXAMINATION? ______
WHAT WOULD YOU MOST LIKE TO HAVE ORTHODONTIC TREATMENT ACCOMPLISH? ______
______

SIGNATURE ______ DATE ______

CHARGES THAT MAY BE INCURRED EXCLUSIVE OF TREATMENT FEE: INITIAL EXAM, INITIAL STUDY MODELS, DIAGNOSTIC CONSULTATION
(If treatment is initiated in our office the consultation and diagnostic fee is exclusive)

A Service charge of 1.5% per month will be applied to all delinquent balances over 90 days.