Patient Information

Date_____

Patient's Name_____
____
Last First Middle
Sex

Address_____
_____
Street City State Zip

Home Phone_____ Birthdate_____Social Security
#_____

Parent's or guardian's name_____ Email
_____

Whom may we thank for referring you to our office?
_____

Responsible Party Information

Name_____
_____
Last First Middle Marital
Status

Residence_____
_____
Street City State Zip

Mailing
Address_____
_
Street City State Zip

How long at this address_____Home Phone_____Cell
Phone_____

Previous Address (if less than 3
yrs.)_____
Street City State Zip

Social Security#_____Birthdate_____Relationship to
Patient_____

Employer_____Occupation_____ Work Phone
_____

Spouse's Name_____Relationship to
Patient_____
Last First Middle

Employer_____Occupation_____ Work
Phone_____

Social Security#_____Birthdate_____Cell
Phone_____

Dental Insurance Information

Insured's Name_____Social
Sec.#_____

Insurance Company_____ _____Group #._____ Subscriber ID
#_____

Insurance Co.
Address_____

Ins. Primary Phone No._____Ins. Secondary Phone
No._____

Do you have dual coverage? Yes No If yes:

Insured's Name_____Social Sec.#_____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address_____

Insured's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____

Release: I authorize release of any information concerning my dental care, advice and treatment to the general dentist and/or dental specialist of record.

Acknowledgement of receipt of notice of privacy practices: By signing I have reviewed this office's Notice of Privacy Practices.

PARENT'S OR GUARDIANS SIGNATURE_____

Updates (date and initial) _____ _____ _____ _____ _____ _____

Patient's School_____
Grade_____

Patient's
Hobbies_____
_____

Patient's
Dentist_____
_____

Last Exam (or Check up) _____ Last Cleaning Date
_____

List any medications or supplements the patient is currently
taking_____

_____
_____

Medical History

Is the patient in good health? Yes No Height_____
Weight_____

Any history of major illness? Yes No

Please
list_____
_____

CHECK ANY OF THE FOLLOWING FOR WHICH PATIENT HAS BEEN TREATED OR DIAGNOSED

____Diabetes ____Asthma ____ Autism/Aspergers

____Pneumonia ____Kidney Involvement ____Valve or Joint Replace/Repair

____Rheumatic Fever ____HIV or AIDS ____Fainting or Dizziness

____Autoimmune Disorders ____Prolonged Bleeding
____Tuberculosis

____Cancer ____Nervous Disorders ____Arthritis

____Anemia ____Hepatitis ____High Blood Pressure

____Epilepsy ____Bone Disorders ____Heart Murmur

Other Serious
Illnesses_____
_____

Does the patient have a tendency to colds? Yes No Sore throats? Yes No Ear infections? Yes No

Have the patient's tonsils been removed? Yes No Adenoids Removed? Yes No
What age?____

List any allergies or drug
sensitivity_____

Dental History

Have there been any injuries to the face, mouth, or teeth? Yes No
Does the patient have any speech problems? Yes No
Is the patient a mouth breather while awake or asleep? Yes No
Have you been informed of any missing or extra permanent teeth? Yes No
Does the patient have any habits affecting the teeth? (e.g. thumb sucking, grinding, clenching)
Yes No
Have you previously consulted an orthodontist? Yes No
Names and ages of other children in
family_____
Reason for consultation, (main concerns):

_____
_____

_____
_____

_____
Parent/Guardian Signature