

**Patient Name:** \_\_\_\_\_ Email Address for Confirmation: \_\_\_\_\_

Patients Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Cell # \_\_\_\_\_

School/Employer: \_\_\_\_\_ Grade/Position: \_\_\_\_\_

Interest/Sports \_\_\_\_\_

**Mother**       **Other (specify)** \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address/Zipcode: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer Name & Address/Zipcode: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**Father**       **Other (specify)** \_\_\_\_\_

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address/Zipcode: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer Name & Address/Zipcode: \_\_\_\_\_ Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_

How Did You Hear About Us?     Dentist     Patient     Relative     Acquaintance     Other \_\_\_\_\_

Whom May We Thank For Referring You To Us? \_\_\_\_\_ Current Dentist: \_\_\_\_\_

Reason For Consultation: \_\_\_\_\_

*Circle Yes or No for which the patient has a history:*

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	TMJ problems	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tooth Grinding	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Neck pain	Y N
Arthritis	Y N	Finger Habit	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Clicking of jaw	Y N
Aspirin	Y N	Thumb Habit	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Headaches	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Gags Easily	Y N	Nervous Disorders	Y N	Seizures	Y N	Popping in jaw	Y N
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N	Diet Pills Taken	Y N
Bone Disorders	Y N	Downs Syndrome	Y N	Mitral Valve Prolapse	Y N	Painful chewing	Y N	Speech problems	Y N	Venereal Disease	Y N
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Tuberculosis	Y N	Hepatitis	Y N

Any disease, problems, or allergies not mentioned above? \_\_\_\_\_

Current Medications? \_\_\_\_\_

Females: Have you started Menstruating? \_\_\_\_\_ At what age? \_\_\_\_\_

Have wisdom teeth been extracted? \_\_\_\_\_ Any face, mouth or teeth injuries? \_\_\_\_\_

Does the patient normally breathe through the mouth while awake or asleep? \_\_\_\_\_ Do gums bleed when brushed or flossed? \_\_\_\_\_

Has an orthodontist been consulted previously? \_\_\_\_\_ Have you had previous orthodontic treatment? \_\_\_\_\_

Are there any missing or extra teeth? \_\_\_\_\_ Have the Tonsils and adenoids been removed? \_\_\_\_\_

Specific TMJ Problem? (Please Circle Those That Apply)    Popping    Clenching    Muscle Soreness    Restricted Opening

Names and Ages of Brothers & Sisters: \_\_\_\_\_

**Insurance Information** (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_  Mother     Father     Step Parent     Self     Other (specify) \_\_\_\_\_

Policy Holders Birthdate: \_\_\_\_\_ \$Maximum \_\_\_\_\_ % Payable \_\_\_\_\_ Age \_\_\_\_\_ Time \_\_\_\_\_

Name of Secondary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_  Mother     Father     Step Parent     Self     Other (specify) \_\_\_\_\_

Policy Holders Birthdate: \_\_\_\_\_ \$Maximum \_\_\_\_\_ % Payable \_\_\_\_\_ Age \_\_\_\_\_ Time \_\_\_\_\_

I understand that credit bureau reports may be obtained. \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_ Date: \_\_\_\_\_