Patient:

Nickname: _____ Email Address: _____

Address: _____ Telephone (Home/Work): _____

How would you like to be contacted for appointment reminders? TEXT EMAIL

Cell phone number: _____ Cell phone carrier:_____

Birthdate: _____ Age: _____ Sex: _____ Race: _____

School/Employer _____ Grade/Position: _____

Interests/Arts/Music/Sports _____

Other family members treated here: _____

Dentist's name: _____ Last Visited: _____

Responsible Party

Parent/Guardian Name (if not self): _____ Telephone (Home/Work): _____

Relationship to Patient: _____

How would you like to be contacted for appointment reminders? TEXT EMAIL

Cell phone number: _____ Cell phone carrier:_____

E-mail: _____

Address: _____
Date of Birth:_____ Employer:_____

Parent/Guardian Name (if not self): _____ Telephone (Home/Work): _____

Relationship to Patient: _____

How would you like to be contacted for appointment reminders? TEXT EMAIL

Cell phone number: _____ Cell phone carrier:_____

E-mail: _____

Address: _____
Date of Birth:_____ Employer:_____

Health History

Abnormal bleeding	___	Bulimia	___	Downs Syndrome	___	Hepatitis	___	Muscular disorders	___	Rheumatic Fever	___
ADD/ADHD	___	Cancer	___	Drug allergies	___	High Blood pressure	___	Nervous Disorders	___	Scoliosis	___
Allergies	___	Cerebral palsy	___	Emotional disorders	___	HIV/AIDS	___	Organ Transplant	___	Seizures	___
Anemia	___	Chest pains	___	Epilepsy	___	Kidney problems	___	Painful chewing	___	Speech problem	___
Arthritis	___	Chronic neck pain	___	Fainting, Dizziness	___	Latex allergies	___	Periodontal problem	___	TMJ problems	___
Aspirin	___		___	Glaucoma	___	Low Blood Pressure	___	Pneumonia	___	Tooth Grinding	___
Asthma	___	Cold Sores/ Herpes	___	Headaches	___	Metal allergies	___	Pregnant	___	Tuberculosis	___
Autoimmune	___	Diabetes	___	Heart condition	___	Mouth breathing	___	Plastic Allergies	___	Operations or Hospitalizations	___

Any disease, problems, or allergies not mentioned above?

_____

Allergies to any medications, metals, latex, vinyl, acrylic, foods?

_____

Current medications, nutrient supplements, herbal medications, or non-prescription medication?

_____

Dental History

Any face, mouth or teeth injuries?

_____

____

Do gums bleed when brushed or flossed?	Y N
Does the patient normally breathe through the mouth while awake or sleep?	Y N
Does your child have any habits that we should be aware of? (thumb sucking, lip biting, tongue thrust)	Y N
Are you presently in any dental pain?	Y N
Do your teeth or jaws ever feel uncomfortable when you awake in the morning?	Y N
Are you aware of your jaw clicking or popping?	Y N
Are you aware of clenching your teeth during the day?	Y N
Have you ever been told that you grind your teeth?	Y N
Female Patients only:	
Are you pregnant?	Y N
Has menstruation started?	Y N
Aware or concerned about under or over developed jaw?	Y N
Any relative with similar tooth or jaw relationships?	Y N
Have you had previous orthodontic treatment?	Y N

How often does your child brush per day? _____ Floss? _____

What is your primary concern? Why are you here?

_____

Do you feel that your concerns are more related to: __Cosmetics _____Prevention _____Function

Any other questions?

_____

____

Financial/Insurance Information

Name of Primary Dental Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Relationship to patient: _____

Insurance ID number: _____ Address: _____

Group # _____ _____

Policy Holders Birthdate: _____ Social Security: _____

Name of Secondary Dental Insurance: _____ Telephone: _____

Name of Policy Holder: _____ Relationship to patient: _____

Insurance ID number: _____ Address: _____

Group # _____

Policy Holders Birthdate: _____ Social Security: _____

Whom may we thank for referring you to us? How did you hear about us? _____

I understand the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any future changes.

Signature: _____ **Relationship To Patient:** _____ **Date:** _____