

Patient Information

Patient's Name _____
Last First Middle
Address _____
Street City State Zip
Home Phone _____ Birthdate _____ Social Security # _____
Email Address _____ General Dentist _____

Responsible Party Information

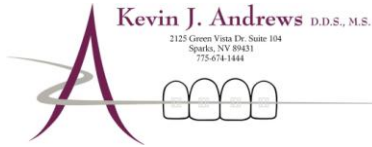
Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs.) _____
Street City State Zip
Do you own or rent? _____ Email Address _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Other Responsible Party Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone _____ Work Phone _____
Previous Address (if less than 3 yrs.) _____
Street City State Zip
Do you own or rent? _____ Email Address _____
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____

Insurance Information

Insured's Name _____ Birthdate _____ Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____
Do you have dual coverage? Yes No If yes: Insured's Employer _____
Insured's Name _____ Birthdate _____ Soc. Sec. # _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____

I understand that when appropriate, a "soft credit check"* may be obtained to assist us in granting you our 0% in-house financing.
*If needed, ask Front Desk personnel for more information.

Signature _____ Date _____



Date _____

Patient's Name _____ Age _____ Birthdate _____

Grade _____ School _____ Names of brothers and sisters _____

Plays musical instrument Yes No Type of musical instrument _____

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

Previous speech therapy? Yes No Hobbies/Interests _____

YES **NO**

Medical History

_____ Is patient presently under a physician's care?

For _____

_____ Is patient taking any pills, medications, or drugs? _____

_____ Has patient ever had an unusual reaction to medication? _____

_____ Is patient allergic to anything? _____

_____ Has patient had any major surgery? For _____

_____ Does patient have a chronic problem with Kidney, Heart, Lung, Liver.

_____ Are there any other medical problems not mentioned above? _____

Describe: _____

_____ Has patient been diagnosed or treated for any of the following:

- Diabetes Arthritis Bone Emotional Epilepsy Anemia
- Endocrine Asthma Fainting Cerebral palsy Prolonged bleeding
- Heart trouble Rheumatic fever Tonsils removed Adnoids removed

YES **NO**

Dental History

_____ Does patient now suck thumb or fingers?

_____ Does patient breathe predominantly through the mouth?

_____ Does the patient clench or grind teeth? at night during day

_____ Does the patient have pain or clicking upon closing the mouth?

_____ Has the patient had any severe head or face injuries? When _____

_____ Have any teeth been injured or chipped due to accidents? When _____

_____ Any noticeable difficulty in chewing or swallowing food?

_____ Has patient been informed of any extra or missing teeth?

_____ Have any teeth (baby or permanent) been removed by extraction? Why _____

_____ Has any member of the family had orthodontic treatment? Who _____

_____ Have you had any previous orthodontic consultation or treatment?

_____ Would patient mind wearing Bands? Headgear?

_____ Has patient ever been teased about appearance of his/her teeth?

_____ Does the patient want his/her teeth straightened?

_____ Has a dentist ever placed a retainer or space maintainer? Month of last dental appointment _____