ABC

Confidential Patient Information

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street City State Zip

Home Phone ______________ Birthdate ______________ Social Security # ______________

School ______________ Grade ________ Hobbies ______________

If patient is a minor , give parent's or guardian's name ______________________________

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

Names and ages of siblings: ______________________________

Date ______________

Confidential Responsible Party Information

Name ______________________________ Marital Status ______________
Last First Middle

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

Social Security # ______________ Birthdate ______________ Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______________

Spouse's Name ______________________________ Relationship to Patient ______________
Last First Middle

Employer ______________ Occupation ______________ No. Years Employed ______________

Social Security # ______________ Birthdate ______________ Work Phone ______________

Dental Insurance Information

Policy Holder's Name ______________________________ and Soc Sec. # ______________

Insurance Company ______________ Group No. ______________ Union Local No. ______________

Insurance Co. Address ______________________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________________

Do you have dual coverage? No ❑ Yes ❑ If yes:

Policy Holder's Name ______________________________ and Soc. Sec. # ______________

Insurance Company ______________ Group No. ______________ Union Local No. ______________

Insurance Co. Address ______________________________ Insurance Co. Phone ______________

Policy Holder's Employer ______________________________

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ______________________________

Phone ______________ Relationship ______________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ______________________________

Updates (date & initial) ______________________________

Patient Information

What are your main reasons for seeking orthodontic treatment? ____________________

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Question		
Have you ever been evaluated or had orthodontic treatment before?	❑ Yes	❑ No
Have there been any injuries to your face, mouth, teeth, or chin?	❑ Yes	❑ No

List any musical instruments played: ____________________

Question		
Have your adenoids and / or tonsils been removed?	❑ Yes	❑ No
Have you been informed of any missing or extra permanent teeth?	❑ Yes	❑ No
Have you even had any pain/tenderness in the jaw joint (TMJ/TMD)?	❑ Yes	❑ No
Do you brush your teeth daily?	❑ Yes	❑ No
Do you floss your teeth daily?	❑ Yes	❑ No

Patient's dentist: ____________________ Date of last visit: ____________________

Patient's physician: ____________________

Phone Number: ____________________ Date of last visit: ____________________

Question			
Are you currently under the care of a physician?		❑ Yes	❑ No
Has puberty begun? (if child)		❑ Yes	❑ No
Has menstruation begun (girls)?		❑ Yes	❑ No
Please describe your current physical health:	❑ Good	❑ Fair	❑ Poor

Please list all the medications that you are currently taking: ____________________

Please list all the medications that you are allergic to: ____________________

Have you ever had any of the following medical problems:

Abnormal Bleeding	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Allergic to Plastic	❑ Yes	❑ No
Allergic to Latex / Metals	❑ Yes	❑ No	Hearing Impairment	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No
Handicaps / Disabilities	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Hepatitis	❑ Yes	❑ No
Any Hospital Stays	❑ Yes	❑ No	Any Operations	❑ Yes	❑ No	Asthma	❑ Yes	❑ No
Kidney / Liver Problems	❑ Yes	❑ No	Cancer	❑ Yes	❑ No	HIV / AIDS	❑ Yes	❑ No
Convulsions / Epilepsy	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Congenital Heart Defect	❑ Yes	❑ No						

Please describe any medical problems you have had: ____________________

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Do you have any of the following habits?			Clenching / Grinding Teeth	❑ Yes	❑ No
Speech Problems	❑ Yes	❑ No	Lip Sucking / Biting	❑ Yes	❑ No
Mouth Breather	❑ Yes	❑ No	Thumb / Finger Sucking	❑ Yes	❑ No
Nail Biting	❑ Yes	❑ No	Tongue Thrust	❑ Yes	❑ No

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

____________________ ____________________

Signature Date