Patient Name: ______________________________________

Birth date: ____

Emergency Contact: _____________________________

Phone: ____

Referred By: □DOCTOR________________________ □ FRIEND/FAMILY________________________ □ STAFF □ INSURANCE
□ GOOGLE □ YAHOO □ MSN □ YELLOWPAGES.COM □ YELLOWPAGES □ YELLOWBOOK.COM □ SELF / WALK-IN
□ OTHER WEBSITE _________________________________ □ MONEY MAILER □ SUPER COUPS

Patient Medical History

Medical Physician:________________________________ Office Phone:______________________________ Date of Last Exam:___________________________

	Yes	No
1.Are you under medical treatment now!	□	□
2.Have you ever been hospitalized for any surgical operation or serious illness within the **last 5 years**?	□	□
If yes, please explain_________________________ ______________________________________		
3.Are you taking any medication(s) including non-prescription medicine?	□	□
If yes, what medication(s) are you taking?_______ ______________________________________		
4.Have you ever taken Phen-Fen/Redux?	□	□
5.Do you use tobacco?	□	□
6.Do you use controlled substances?	□	□
7.Are you wearing contact lenses?	□	□

9.Are you allergic to or have you had any reactions to the following:	Yes	No
Local Anesthetics (eg. Novacaine)	□	□
Penicillin or any other Antibiotics	□	□
Sulfa Drugs	□	□
Barbiturates	□	□
Sedatives	□	□
Iodine	□	□
Aspirin	□	□
Any Metals (eg. Nickel, mercury etc.)	□	□
Latex Rubber	□	□
Other____________________________________	□	□

10.Women Only:	Yes	No
Are you pregnant or think you may be pregnant?	□	□
Are you nursing?	□	□
Are you taking oral contraceptives?	□	□

8.Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	□	□	Heart Disease	□	□	Chest Pains	□	□
Heart Attack	□	□	Cardiac Pacemaker	□	□	Easily Winded	□	□
Rheumatic Fever	□	□	Heart Murmur	□	□	Stroke	□	□
Swollen Ankles	□	□	Angina	□	□	Hay Fever/Allergies	□	□
Fainting/Seizures	□	□	Frequently Tired	□	□	Tuberculosis	□	□
Asthma	□	□	Anemia	□	□	Radiation Therapy	□	□
Low Blood Pressure	□	□	Emphysema	□	□	Glaucoma	□	□
Epilepsy/Convulsions	□	□	Cancer	□	□	Recent Weight Loss	□	□
Leukemia	□	□	Arthritis	□	□	Liver Disease	□	□
Diabetes	□	□	Joint Replacement or Implants	□	□	Heart Trouble	□	□
Kidney Disease	□	□	Hepatitis/Jaundice	□	□	Respiratory Problems	□	□
AIDS or HIV Infection	□	□	Sexually Transmitted Disease	□	□	Mitral Valve Prolapse	□	□
Thyroid Problem	□	□	Stomach Troubles/Ulcers	□	□	Other_________________________________	□	□

Patient Dental History

Dentist:___________________________________ Office Phone:________________________________ Date of Last Exam:______________________________

	Yes	No
1.Do your gum bleed while brushing or flossing?	□	□
2.Are your teeth sensitive to hot or cold liquids/foods?	□	□
3.Are your teeth sensitive to sweet or sour liquids/foods?	□	□
4.Do you feel pain to any of your teeth?	□	□
5.Do you have any sores or lumps in or near your mouth?	□	□
6.Have you ever had traumatic incident involving your teeth?	□	□

7.Summarize your history of dental treatment:_____________________
____

	Yes	No
8.Have you had any orthodontic treatment?	□	□
9.Do you like your smile?	□	□

10.Chief orthodontic complain____________________________________
____

11.Why are you seeking orthodontic care now?______________________
____

12.What do you expect from orthodontic treatment?__________________
____

Hobbies/Interests____
____

Favorite Sports____
____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____________________________________
Signature of patient (or parent if minor)

Date________________________________

Doctor's Comments ____
____
____ Signature ____________________________ Date ______________________________

Patient Information

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other: ____________________

Patient Name: ____________________

First Middle Last (Name Called)

Birthday: ____________________

Home Phone: ____________________ Work Phone: ____________________

Address: ____________________

Address: ____________________

City, State Zip Code: ____________________

Sex M ☐ F ☐ SSN: ____________________ Race: ____________________

Dentist: ____________________

Physician ____________________

Who referred you to our practice? ____________________

Any Medical Problems? ____________________

Responsible Party Information

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. ☐ Other: ____________________

Responsible Party Name: ____________________

First Middle Last (Name Called)

Birthday: ____________________

Home Phone: ____________________ Work Phone: ____________________

Address: ____________________

Address: ____________________

City, State ZipCode: ____________________

Sex M ☐ F ☐ SSN: ____________________ Relationship to Patient: ____________________

Is this Responsible Party Financially Responsible for Charges? yes ☐ no ☐

Is this the Primary Person who brings patient to appointments? yes ☐ no ☐

Insurance Company: ____________________

Group Number: ____________________ Phone: ____________________

Address: ____________________

Employer: ____________________

Address: ____________________

Additional Information

List Family Members that are currently in our practice: ____________________

____

____

Other Information: ____________________

____

____