



PATIENT INFORMATION

Name _____ Date _____
 Nickname _____
 Birthdate ____/____/____ Age _____ M F
 Address _____
 City _____ State _____ Zipcode _____
 Previous address (if less than 3 years) _____

 Home Phone _____ Wk# _____
 Other phone _____ Marital Status S M D
 Dentist _____ Last visit _____
 Favorite Sports or Hobbies _____
 School _____ Grade _____
 Parent or Legal Guardian _____
 Patients Residence: Both Parents Mother Father
 Other _____
 Incase of Emergency Contact _____
 Phone # _____ Relationship _____

INSURANCE INFORMATION YES NO

Primary Insurance Company _____
 Insured Name _____
 Contact # _____ Group # _____
 Subscriber # _____ Employer _____
 Coverage Amount _____ % up to _____ max _____ deduct _____
Secondary Insurance Company _____
 Insured Name _____
 Contact # _____ Group # _____
 Subscriber # _____ Employer _____
 Coverage Amount _____ % up to _____ max _____ deduct _____
Third Insurance Company _____
 Insured Name _____
 Contact # _____ Group # _____
 Subscriber # _____ Employer _____
 Coverage Amount _____ % up to _____ max _____ deduct _____

REFERRAL

WHO REFERRED YOU TO OUR OFFICE?

- Dentist _____
- Friend _____
- Yellow Pages _____
- Other _____

MOTHER'S INFORMATION

Mom Step Mom Guardian

Name _____ Birthdate _____
 Address _____
 City _____ State _____ Zipcode _____
 Home # _____ Wk # _____
 Employer _____ Job title _____
 No. of years employed _____ Marital Status S M D
 SSN _____ DL# _____
 Email _____

FATHER'S INFORMATION

Father Step Father Guardian

Name _____ Birthdate _____
 Address _____
 City _____ State _____ Zipcode _____
 Home # _____ Wk # _____
 Employer _____ Job title _____
 No. of years employed _____ Marital Status S M D
 SSN _____ DL# _____
 Email _____

PERSON FINANCIALLY RESPONSIBLE

Name _____ Birthdate _____
 Address _____
 City _____ State _____ Zipcode _____
 Home # _____ Wk # _____
 Employer _____ Job title _____

Orthodontics for kids of all ages!!!
 Please complete the Dental and Medical History on the back page
 Thank You!

In your words, what is the orthodontic problem? _____

Have you had any previous orthodontic treatment or consultation? Yes No

If so, what work was completed, and by whom? _____

Has any other family member had orthodontics? _____

If so, what work was completed and by whom? _____

Were the results acceptable? Yes No

Do you now have or have you ever experienced pain or discomfort in your jaw joints? Yes No

Do you grind your teeth? Yes No

Do you have any speech problems? Yes No

Do you have or have you ever had any thumb or finger sucking habits? Yes No

Do you usually breathe through your mouth while awake? Yes No

Have you ever experienced an adverse reaction during a medical or dental procedure? Yes No

Have you ever received serious trauma or injury to the teeth, face, jaws or head? Yes No

Will you best describe the patients attitude toward orthodontic treatment:

Wants treatment Treatment is necessary Unwilling, but agrees Uncooperative

Medical History

Do you have, or have you ever had: Diabetes Heart Murmur Artificial joints or heart valves

Are you under the care of a physician for any specific condition? Yes No

If yes, please describe _____

Are you taking any medication? Yes No

If yes, please list _____

Please check if you have had any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV positive | <input type="checkbox"/> Convulsions or Epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Asthma or hayfever | <input type="checkbox"/> Endocrine or Growth Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Tuberculosis |

Authorization

I understand and acknowledge that I am financially responsible for the service provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and helpful orthodontic treatment. If there is any changes in my dental or medical status, I will inform Dr. Price.

Signature _____ Date _____