



Date \_\_\_\_\_

Patients' Full Name \_\_\_\_\_ Nickname \_\_\_\_\_

Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # \_\_\_\_\_

**Patient over 18 years old:**

Home Address \_\_\_\_\_

Employed by \_\_\_\_\_ Bus. Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Full Name \_\_\_\_\_ Employed by \_\_\_\_\_ Phone \_\_\_\_\_

**Patient under 18 years old:**

School \_\_\_\_\_ Grade \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Home Address \_\_\_\_\_

Father Employed by \_\_\_\_\_ Bus. Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother Employed by \_\_\_\_\_ Bus. Address \_\_\_\_\_ Phone \_\_\_\_\_

**All patients' please fill out the remainder of the form:**

Person Responsible for Account \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

Family Dentist \_\_\_\_\_ Last visit: \_\_\_\_\_ Physician \_\_\_\_\_

Is there any orthodontic insurance we can check for you? .....  Yes  No

If so, list Insurance Company \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder \_\_\_\_\_ SSN# \_\_\_\_\_ Employer \_\_\_\_\_

Relatives treated at this office \_\_\_\_\_

Have you been under the care of a physician during the past two years? .....  Yes  No

(If so, state condition and duration) \_\_\_\_\_

**Please check any of the following for which you have been treated:**

- Diabetes
- Pneumonia
- Heart Trouble
- Bone Disorders
- Anemia
- Asthma
- Rheumatic Fever
- Tuberculosis
- Epilepsy
- Nervous Disorder
- Kidney Trouble
- Endocrine Problem
- Fainting or Dizziness
- Hepatitis or Jaundice
- HIV
- Prolonged Bleeding

List any medications now being taken \_\_\_\_\_

List any allergies or drug sensitivity \_\_\_\_\_

Have your tonsils or adenoids been removed? (At what age? \_\_\_\_\_) .....  Yes  No

Have you ever sucked your thumb or finger? (Until what age? \_\_\_\_\_) .....  Yes  No

Do you have any speech problems? .....  Yes  No

Are you a mouth breather? .....  Yes  No

Do you play a musical wind instrument? .....  Yes  No

Has another orthodontist been consulted previously? .....  Yes  No

Whom may we thank for referring you to our office? \_\_\_\_\_

Signature of Patient, Parent, or Guardian \_\_\_\_\_ Date \_\_\_\_\_