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We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

Patient Information

Name _____ Sex () M () F
Last Name First Name MI Parent Name(s)

Address _____ City _____ Zip _____

Phone _____

Age _____ Birthdate _____ It patient is a minor are parents: Married () Single () Widowed () Separated () Divorced

Whom may we thank for referring you? _____

Notify in case of Emergency _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Group # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional Insurance? () Yes () No

Subscriber Name _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc Sec # _____

Address (if different from patient) _____ Phone # _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Group # _____

Name of other dependents under this plan _____

Please complete both sides

Medical History

Physician's Name _____ Dentist's Name _____

Patient's Height _____ Weight _____ Mother's Height _____ Father's Height _____

Brother's Ages _____ Sister's Ages _____

Women: Are you pregnant? () Y () N

Check (x) if you have had any of the following

- | | | |
|-------------------------|---------------------------------------|-----------------------|
| () AIDS | () Cancer | () Hepatitis |
| () Allergies | () Diabetes | () Heart Disease |
| () Arteriosclerosis | () Dizziness | () Hearing Disorder |
| () Autoimmune Disorder | () Epilepsy | () Kidney Disease |
| () Blood Disease | () Endocrine Problems | () Ringing of Ears |
| () High Blood Pressure | () Emotional Problems | () Sleep Disturbance |
| () Low Blood Pressure | () Frequent sore throats/Tonsillitis | () Snoring |
| () Bone Disorders | () Have Speech Problems | () Other _____ |

Please list any medication you are presently taking _____

Are you allergic to any medication? _____

Do you require antibiotic pre-medication when going to the dentist? _____

What are your main concerns you (or the parent) have about your teeth or jaws?

- | | | |
|------------------------------|----------------------------------|--------------------------------|
| () "Buck teeth" | () Irregular facial proportions | () Clicking jaw joint |
| () Crowding | () Prominent jaw | () Headaches and facial pain |
| () Gum disease | () Receding jaw | () Jaw pain |
| () Gummy smile | | () Limited jaw opening |
| () Irregularly shaped teeth | | () Ringing/stuffiness of ears |
| () Missing teeth | | () Other _____ |
| () Overbite | | |
| () Protrusion of teeth | | |
| () Spaces | | |

Are there any other family members with similar orthodontic conditions?

() Father () Mother () Brother () Sister () Other _____

Do you breath through your mouth rather than your nose? () Seldom () Sometimes () Usually

How often do you have dental check-ups? _____ When was your last dental check-up? _____

Have you ever received trauma or injury to your teeth , face, jaws, or head? _____

Are there any other medical, dental, or surgical problems not covered? _____

Have you had a previous orthodontic consultation or treatment? _____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. If there is any change in my medical status I will inform the orthodontist.

I authorize my insurance company to pay the orthodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I understand that I am financially responsible whether or not paid by insurance.

Signature _____ Date _____

