

Personal InformationPatient's Name _____
First Middle Last (Nickname)Address _____
Street City State Zip

Birthday _____ Age _____ Male _____ Female _____ Adopted _____

Home # _____ Cell # _____ Email: _____

Whom may we thank for referring you? _____ Dentist _____

Names & Birthday of Children or Siblings _____

Occupation _____ School _____ Grade _____

Hobbies/Interests _____

Parent Information

Name of Parents/Guardians _____ Email: _____

Father's First Name _____ DOB _____ Work # _____ Cell # _____

Employer and Address _____

Mother's First Name _____ DOB _____ Work # _____ Cell # _____

Employer and Address _____

Adults

Employer _____ SSN _____

Work # _____ Cell # _____ Email: _____

Spouse's Name _____

Billing Information

Person Responsible for Account _____ SSN _____

Billing Address _____

Street City State Zip

Home # _____ Work # _____ Cell # _____

Insurance Information

Insured's Name _____ SSN _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Do you have dual coverage? Yes No If Yes:

Insured's Name _____ SSN _____

Insurance Company _____ Group # _____ Local # _____

Insurance Co. Address _____

Insured's Employer _____

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

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Health History

Is Patient presently under care of Physician? Yes No Family Physician _____

Reason _____

Please check box if Patient had or currently has:

- | | | | | |
|---|---|---------------------------------------|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Bisphosphonate treatment (Fosomax) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychiatric Treatment | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Tonsils Removed | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Adenoids Removed | | <input type="checkbox"/> Herpes | | |
- List any medication now being taken: _____
Any drug sensitivities/allergies? _____

Dental History

What concerns you most about your teeth? _____

Have you had a previous Orthodontic consult? _____

Please check all those that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Clench or Grind your teeth | <input type="checkbox"/> Hear noises from the jaw joints | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Have frequent headaches? | <input type="checkbox"/> Recent Jaw or Facial injury | <input type="checkbox"/> Speech Problems |

Clinical Examination

(to be filled out by doctor)

Teeth Present: _____ | _____ 1° Concern _____

Maxillary Arch: ALD ALE _____ Notes: _____

Mandibular Arch: ALD ALE _____ Notes: _____

Class R _____ L _____

Midline R _____ | _____ L

OJ _____ mm OB _____ %

Oral Hygiene _____

Crossbite R _____ | _____ L

Recession _____ Caries _____

Profile _____

Smile Line _____

Lip Strain _____

CR-CO Shift _____

Opening Width _____ mm

Allergies/Asthma _____

Comments: _____

Estimated Treatment Time: _____

Estimated Treatment Fee: _____

♀ ♂ Dr. _____