



Patient Information

Today's Date _____ Male Female

Name _____
 Last First MI

Common Name _____

Date of Birth _____ Age _____

Patient E-mail _____

School _____

Patient's Hobbies/Interests _____

Medical/Dental History

General Dentist _____

Last Dental Visit _____

Is the patient under the care of a physician for a specific problem at this time? _____

Physician's Name _____

Are you taking any prescription medication? Yes No
 If so, which ones? _____

Are you currently taking a bisphosphonate for osteoporosis?
 Yes No Fosamax Boniva Actonel Other

List any drug sensitivities _____

Adolescent patients only

Is the patient adopted? Yes No

Has the patient reached puberty? Yes No

Girl: Has she started menstruation? Yes No
 If yes, month/year _____

Boys: Has his voice changed? Yes No

Please check all of the following that apply

Asthma <input type="checkbox"/>	Jaw Joint Pain <input type="checkbox"/>	AIDS/HIV <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Bone Disorders <input type="checkbox"/>	Heart Condition <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Teeth Grinding <input type="checkbox"/>	Kidney Problems <input type="checkbox"/>
Hepatitis <input type="checkbox"/>	ADD/ADHD <input type="checkbox"/>	Endocrine Problems <input type="checkbox"/>

Have you been informed of any missing/extra teeth? Yes No

Has an orthodontist previously been consulted? Yes No

Have you had any previous orthodontic treatment? Yes No

Responsible Party Information

Name _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

Married Divorced Separated Single Widowed

Responsible Party's E-mail (allows online access to photos/x-rays/financials)

Spouse/Other _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

Are there any other children that you would like us to evaluate?
 Yes No _____

Family members previously treated here _____

How did you decide to come to our office?

Insurance

Primary Dental Insurance

Orthodontic Coverage? Yes No

Insured's Name _____

Relationship to Patient _____

Employer _____

Insurance Company _____

Date of Birth _____ ID / SS# _____

Insurance Phone # _____

Secondary Dental Insurance

Orthodontic Coverage? Yes No

Insured's Name _____

Relationship to Patient _____

Employer _____

Insurance Company _____

Date of Birth _____ ID / SS# _____

Insurance Phone # _____