

Richard E. Boyd D.M.D, M.S.
Specialist in Orthodontics

Date _____

Date of Birth _____

Name _____
First Middle Last

Age _____ Male Female

Address _____ Phone # _____

School /Employer _____ Grade/Occupation _____ Patient's Dentist _____

Last Visit to Dentist _____ Patient's Hobbies or Interest _____

Responsible Party E-mail Address (allows access to x-rays, financials, etc.) _____

Please list names of other children in family if applicable. _____

Please list any family members previously treated here. _____

**Is there someone other than your dentist that we may thank for referring you to our office?
(friends, patients, neighbors, etc.)** _____

Responsible Party Information

Name _____ Relationship to patient _____

Employer _____ Work # _____ Occupation _____

Spouse's Name (if applicable) _____

Employer _____ Work # _____ Occupation _____

Marital Status of Responsible Party: Married Divorced Separated Single Widowed

Does patient have insurance that covers orthodontic treatment? Yes No If yes, then:

Name of Insured _____ Relationship to patient _____
First Middle Last

Employer _____ (if different than above)

Insurance Co. _____ Date of birth _____

Employee ID (or SS#)* _____ Phone # of insurance Co. _____

***(Insurance companies are required to provide an I.D. # other than your Social Security number for prevention of I.D. theft)**

Is patient covered under another dental plan? Yes No If yes, please complete the following :

Name of Insured _____ Relationship to patient _____
First Middle Last

Employer _____ Occupation _____

Insurance Co. _____ Date of birth _____

Employee ID (or SS#)* _____ Phone # of insurance Co. _____

Medical/Dental History

Is the patient under the care of a physician for a specific problem at this time? Yes No Illness _____

List any medications patient is currently taking _____

List any drug sensitivities _____

Is there a history of major illness, accident or operation? _____

Adolescent patients only: Is the patient adopted? Yes No

Has the patient reached puberty? Girls: 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:

Diabetes Heart Trouble Grinding of Teeth Kidney Problems High Blood Pressure

Hepatitis Allergies/Asthma Rheumatic Fever Bleeding Problems Bone Disorders

Epilepsy Jaw Joint Pain Endocrine Problems Nervous Disorders Liver Disease AIDS/HIV

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

Has an orthodontist been consulted previously? Yes No

Have you had any previous orthodontic treatment? Yes No If so, by whom? _____

Signature of Parent, Patient or Guardian