

PATIENT'S NAME: _____ (Last) (First) NICK NAME: _____ (Preferred Name) MARITAL STATUS: _____ (S / M / D / W)
 ADDRESS: _____ (Street Address) (City) (State) (Zip) HOME PHONE: (_____) _____ - _____
 OCCUPATION: _____ EMPLOYER: _____ (Name of school if patient is a student) WORK PHONE: (_____) _____ - _____
 DATE OF BIRTH: ____ / ____ / ____ SS No: ____ - ____ - ____ DENTIST: _____ PHONE: _____
 REFERRED BY: _____ FAMILY MEMBERS IN TREATMENT: _____

FATHER / HUSBAND: _____ (Last) (First)
 ADDRESS: _____ (Street Address) (City) (State) (Zip) HOME PHONE: (_____) _____ - _____
 OCCUPATION: _____ EMPLOYER: _____ (Name of school if a student) WORK PHONE: (_____) _____ - _____
 DATE OF BIRTH: ____ / ____ / ____ SS No: ____ - ____ - ____

MOTHER / WIFE: _____ (Last) (First)
 ADDRESS: _____ (Street Address) (City) (State) (Zip) HOME PHONE: (_____) _____ - _____
 OCCUPATION: _____ EMPLOYER: _____ (Name of school if a student) WORK PHONE: (_____) _____ - _____
 DATE OF BIRTH: ____ / ____ / ____ SS No: ____ - ____ - ____

FRIEND OR NEIGHBOR: _____ (Preferably a person who is not a relative) TELEPHONE: (_____) _____ - _____

PRIMARY		ORTHODONTIC INSURANCE		SECONDARY	
ORTHODONTIC COVERAGE:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ORTHODONTIC COVERAGE:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ORTHODONTIC COVERAGE:	<input type="checkbox"/> NO <input type="checkbox"/> YES
INSURANCE CO. NAME:	_____	INSURANCE CO. NAME:	_____	INSURANCE CO. NAME:	_____
INSURANCE CO. ADDRESS:	_____	INSURANCE CO. ADDRESS:	_____	INSURANCE CO. ADDRESS:	_____
INSURANCE CO. PHONE #:	_____	INSURANCE CO. PHONE #:	_____	INSURANCE CO. PHONE #:	_____
GROUP # (PLAN OR POLICY #):	_____	GROUP # (PLAN OR POLICY #):	_____	GROUP # (PLAN OR POLICY #):	_____
LIFETIME MAXIMUM BENEFIT:	_____	LIFETIME MAXIMUM BENEFIT:	_____	LIFETIME MAXIMUM BENEFIT:	_____
INSURED'S NAME:	_____	INSURED'S NAME:	_____	INSURED'S NAME:	_____
INSURED'S RELATION TO PATIENT:	_____	INSURED'S RELATION TO PATIENT:	_____	INSURED'S RELATION TO PATIENT:	_____
INSURED'S DATE OF BIRTH:	____ / ____ / ____	INSURED'S DATE OF BIRTH:	____ / ____ / ____	INSURED'S DATE OF BIRTH:	____ / ____ / ____
INSURED'S EMPLOYER:	_____	INSURED'S EMPLOYER:	_____	INSURED'S EMPLOYER:	_____

MEDICAL HISTORY

HEALTH QUALITY: GOOD FAIR POOR ALLERGIES: 1. FOOD 2. DRUG 3. HAYFEVER 4. ASTHMA 5. LATEX 6. OTHER
 PLEASE EXPLAIN: _____
Please give any details explaining the allergies. List by number. (Example: #2, sulfa drugs)

HAS THE PATIENT HAD ANY OF THE FOLLOWING: (Please check)

- | | | | | | |
|---|---|---|--|--|--|
| 1 <input type="checkbox"/> HEPATITIS | 6 <input type="checkbox"/> DIABETES | 11 <input type="checkbox"/> KIDNEY PROBLEMS | 16 <input type="checkbox"/> SINUS PROBLEMS | 21 <input type="checkbox"/> IMMUNE DISORDER | 26 <input type="checkbox"/> LIP OR TONGUE BITING |
| 2 <input type="checkbox"/> FREQUENT HEADACHES | 7 <input type="checkbox"/> HEART DISEASE | 12 <input type="checkbox"/> BLEEDING GUMS | 17 <input type="checkbox"/> ARTHRITIS | 22 <input type="checkbox"/> SPEECH IMPAIRMENT | 27 <input type="checkbox"/> NAIL BITING |
| 3 <input type="checkbox"/> CEREBRAL PALSY | 8 <input type="checkbox"/> EPILEPSY | 13 <input type="checkbox"/> LIVER DISEASE | 18 <input type="checkbox"/> CONVULSIONS / SEIZURES | 23 <input type="checkbox"/> TONSILS / ADENOIDS | 28 <input type="checkbox"/> TUBERCULOSIS |
| 4 <input type="checkbox"/> RHEUMATIC FEVER | 9 <input type="checkbox"/> EXCESSIVE BLEEDING | 14 <input type="checkbox"/> COLD SORES / FEVER BLISTERS | 19 <input type="checkbox"/> THROAT INFECTIONS | 24 <input type="checkbox"/> MOUTH BREATHING | 29 <input type="checkbox"/> HEMOPHELIA |
| 5 <input type="checkbox"/> FREQUENT COLDS | 10 <input type="checkbox"/> THYROID PROBLEMS | 15 <input type="checkbox"/> DIZZINESS OR FAINTING | 20 <input type="checkbox"/> GRINDING OF TEETH | 25 <input type="checkbox"/> THUMB / FINGER SUCKING | 30 <input type="checkbox"/> DIFFICULT NOSE BREATHING |
| | | | | 31 <input type="checkbox"/> OTHER | |

PLEASE EXPLAIN: _____
Please give any details explaining the checked items. List by number. (Example: #23, Tonsils removed at age 3)

PHYSICIAN: _____ UNDER PHYSICIAN'S CARE AT PRESENT? (Y or N): _____
 FOR WHAT: _____
 LIST DRUGS REGULARLY TAKEN & REASON: _____

DENTAL HISTORY

LAST DENTAL VISIT: ____ / ____ / ____ DENTAL WORK BEING DONE NOW? ____ IF YES, WHAT? _____
 HAS THE PATIENT EVER RECEIVED A BLOW TO THE TEETH OR JAW? ____ IF YES, EXPLAIN: _____
 HAS THE PATIENT HAD ORTHODONTIC TREATMENT OR EVALUATION? ____ IF YES, BY WHOM? _____ WHEN: ____ / ____ / ____
 WHAT DO YOU FEEL ARE THE ORTHODONTIC PROBLEMS? ALIGNMENT OF TEETH DENTAL PROTRUSION FACIAL FEATURES OTHER _____
 WHO FIRST NOTICED THE NEED FOR ORTHODONTIC TREATMENT? _____

ADDITIONAL COMMENTS: _____
 I certify that I have answered the above questions to the best of my ability. I will not hold Orthodontics, Inc., or any member of it's staff, responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and / or diagnosis.
 _____ / ____ / ____
 Signature of Patient (Parent or Guardian if patient is a minor) Date