Name:

First Appointment:

Nickname: ____________________

Patients Address: ____________________ Zip: __________ Telephone: __________

Birthdate: __________ Age: __________ Sex: __________ Race: __________

School/Employer: ____________________ Grade/Position: __________

Interest/Sports ____________________

Primary

€ Mother € Father € Step Parent € Self € Other (specify) __________

Responsible Party: ____________________ Telephone: __________

Address: ____________________ Zip: __________ How Long? __________

Employer & Address: ____________________ Telephone: __________

Social Security Number: __________ E-mail: __________

Secondary

€ Mother € Father € Step Parent € Self € Other (specify) __________

Responsible Party: ____________________ Telephone: __________

Address: ____________________ How Long? __________

Employer/Address: ____________________ Telephone: __________

Social Security Number: ____________________

How Did You Hear About Us? € Dentist € Patient € Relative € Acquaintance € Other __________

Whom May We Thank For Referring You To Us? __________ Present Dentist: __________ Last Visit: __________

Reason For Consultation: ____________________

Circle Yes or No for which the patient has a history:

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Periodontal problems	Y N	Tooth Grinding	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pneumonia	Y N	Tuberculosis	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Latex allergy	Y N	Pregnant	Y N	Venereal Disease	Y N
Arthritis	Y N	Chronic neck pain	Y N	Fainting, Dizziness	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Thumb Sucking	Y N
Aspirin	Y N	Clicking of jaw	Y N	Glaucoma	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Food Allergies	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Headaches	Y N	Muscular disorders	Y N	Scoliosis	Y N	Latex Allergies	Y N
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Nervous Disorders	Y N	Seizures	Y N		
Bone Disorders	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Organ Transplant	Y N	Speech problems	Y N		
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Painful chewing	Y N	TMJ problems	Y N		

Any disease, problems, or allergies not mentioned above? ____________________

Current Medications? ____________________

Females: Have you started Menstruating? __________ At what age? __________

Have wisdom teeth been extracted? ______ Any face, mouth or teeth injuries? ______

Does the patient normally breathe through the mouth while awake or asleep? ______ Do gums bleed when brushed or flossed? ______

Has an orthodontist been consulted previously? ______ Have you had previous orthodontic treatment? ______

Are there any missing or extra teeth? ______ Have the Tonsils and adenoids been removed? ______

Any other questions? ______

Names and Ages of Brothers & Sisters: ______

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: ______ Telephone: ______

Name of Policy Holder: ______ € Mother € Father € Step Parent € Self € Other (specify) ______

Policy Holders Birthdate: ______

Name of Secondary Orthodontic Insurance: ______ Telephone: ______

Name of Policy Holder: ______ € Mother € Father € Step Parent € Self € Other (specify) ______

Policy Holders Birthdate: ______

Signature: ______ Relationship To Patient: ______ Date: ______