ORTHODONTIC PATIENT INFORMATION Acct. No. _____

Patient Name_____ Home Phone_____
Birth Date_____ Age_____ Sex_____ Hobbies/Sports_____
Home Address_____ Referred by?_____

FOLLOWING INFORMATION APPLIES TO PERSON RESPONSIBLE FOR PAYMENT:

Name_____ Relationship_____ Soc. Sec. No._____
Employed By_____ Occupation_____
Bus. Address_____ Bus. Phone_____
Dental Insurance_____ Group No._____
Insurance Address_____ Insurance Phone_____
Name of Secondary Insurance (if applicable)_____
Secondary Insurance Group No._____ Was Benefit Ever Used? .... ☐ Yes ☐ No

MEDICAL HISTORY

Please circle those conditions that pertain to the Patient:

Endocrine Problems	Rheumatic Fever	Aids	Tuberculosis	Fainting/Dizziness
Bone disorder	Heart Problems	Diabetes	Epilepsy	Asthma/Allergy
Prolonged Bleeding	Hepatitis	Anemia	Pneumonia	Allergy to Penicillin
Nervous Disorder	Liver Problems	Cancer	Kidney Problems	Allergy to certain drugs

Others not listed_____ Family members with these symptoms_____
Does patient often have: ____colds ____sore throat ____ear infection. Have tonsils been removed?_____ What age?_____
List medications and purpose of each _____
Hospitalized recently? ☐ Yes ☐ No Reason_____
Physician's Name_____ City/State_____ Phone No._____

Answer the following if patient is a minor:

Has patient reached puberty? (Boy has voice changed; Girl has menstruation begun) ..... ☐ Yes ☐ No
Height_____ Weight_____ Breast Fed Only ☐ To what Age?_____ Breast Fed and Bottle Fed ☐ Bottle Fed Only ☐

DENTAL HISTORY

History of injury to face, mouth or teeth? ..... ☐ Yes ☐ No
History of sucking thumb/finger or lip ..... ☐ Yes ☐ No
Does patient snore when sleeping? ..... ☐ Yes ☐ No
Difficulty in breathing through the nose? ..... ☐ Yes ☐ No
Is Patient a mouth breather? ..... ☐ Yes ☐ No
While awake? ..... ☐ Yes ☐ No
While asleep? ..... ☐ Yes ☐ No
Had either parent orthodontic treatment? ☐ Yes ☐ No
Frequent migraine headaches? ☐Yes ☐No Stuffiness or Ringing in the ear? ☐Yes☐No Dizziness or Vertigo? ☐ Yes ☐ No
List any musical instruments played _____
Has the patient had previous orthodontic consultation or treatment? ☐ Yes ☐ No With whom? _____
Name of attending Dentist_____ City/State_____ Phone No._____
Please describe the problem you see and what you expect from treatment: _____

_____

OFFICE POLICY REGARDING PAYMENT OF FEES

Payment is expected for service rendered at the time of the first visit. Financial arrangements for subsequent treatment will be made following diagnosis and treatment plan presentation.

Patient's Signature (Parent's if Patient is a minor)_____Date_____

Thank You For Coming To Our Office