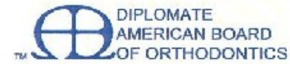

To be completed by an adult; these questions are of great help to us for a better understanding of your child.

Patient Information

Date ______

Patient's Name ______

Nickname ______

Address ______

City ______ State ______ Zip ______

Home Phone ______

Birthdate ______ Age ______

Social Security # ______

School ______ Grade ______

Hobbies/Interests ______

Responsible Party Information

Name ______

Address ______

City ______ State ______ Zip ______

Home Phone ______ Work Phone ______

Social Security # ______ Birthdate ______

Driver's License # ______

Relationship to Patient ______

Employer ______

Employer Address ______

Occupation ______

Spouse's Name ______

Social Security # ______

Driver's License # ______

Employer ______

Employer Address ______

Occupation ______

Work Phone ______ Birthdate ______

Relationship to Patient ______

I understand that where appropriate, credit bureau reports may be obtained. Signature (Parent's signature if minor)

______ Date ______

Dental Insurance Information

Insured's Name ______

Relationship to Patient ______

Insured's Home # ______ Work# ______

Insured's Social Security # ______ Birthdate ______

Insurance Company ______

Group # ______ Insur. Co. Phone# ______

Insurance Co. Address ______

City ______ State ______ Zip ______

Medical/Dental History

Family Dentist ______

Date of last dental exam ______

Primary concern regarding tooth alignment? ______

______

Has patient received any Orthodontic Treatment?
☐ No or ☐ Yes Dr. Name ______

Is another member of your family a patient at our office?
☐ No or ☐ Yes Name ______

Who may we thank for referring you to our office?

______

Patient's Physician ______

Check any of the medical conditions, which apply:

___ Asthma	___ Heart Problems	___ Hepatitis
___ Chronic Sinus	___ Rheumatic Fever	___ Diabetes
___ Freq. Colds	___ Blood Disease	___ Seizures
___ Freq. Headaches	___ A.I.D.S.	___ Hormonal Problems

Tonsils Removed ☐ No / ☐ Yes Age ______

Adenoids Removed ☐ No / ☐ Yes Age ______

Other physical or mental considerations? ______

Drugs or Medications being taken/reasons ______

______

Drugs or Allergy sensitivity ______

Injuries to head, face or teeth ______

Has patient reached puberty? ☐ No ☐ Yes

Habits: Thumb/Finger Sucking ☐ No ☐ Yes
Grinding/Clenching Teeth ☐ No ☐ Yes
Mouth Breathing ☐ No ☐ Yes
Lip/Cheek Biting ☐ No ☐ Yes

Speech Problem ☐ No ☐ Yes

What Sounds? ______

Jaw Joint Noise or Discomfort
☐ No ☐ Yes - see receptionist for form

Did Father have Orthodontic treatment?
☐ No ☐ Yes Age ____ Dr. ______

Did Mother have Orthodontic treatment?
☐ No ☐ Yes Age ____ Dr. ______

How many brothers? ______ Ages: ______

How many sisters? ______ Ages: ______

Is patient adopted? ☐ No ☐ Yes

Describe patient's temperament ______

Describe patient's attitude toward wearing braces ______