

**PATIENT INFORMATION**

A B C

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

How long at this address? \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell/other phone \_\_\_\_\_ Email address \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? \_\_\_\_\_  
Yes No Do you have a history of a major illness? \_\_\_\_\_  
Yes No Have you had any operations? \_\_\_\_\_  
Yes No Have you ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

Please circle if you are allergic to any of the following:

Aspirin Erythromycin Penicillin Codeine Tetracycline Dental Anesthetics

Latex Jewelry/Metals

Please list any other drugs/materials that you are allergic to: \_\_\_\_\_

## DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
What concerns you most about your teeth? \_\_\_\_\_

Yes No Are you presently in any dental pain? \_\_\_\_\_  
Yes No Have you ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Have you ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_  
Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_  
Yes No Do your gums bleed when you brush? \_\_\_\_\_  
Yes No Do you have any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Are you a mouth breather? \_\_\_\_\_  
Yes No Have you ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No What is your attitude toward receiving orthodontic treatment? \_\_\_\_\_  
Yes No Has anyone in your family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? \_\_\_\_\_  
Yes No Are you aware of your jaw clicking or popping? \_\_\_\_\_  
Yes No Are you aware of clenching your teeth during the day? \_\_\_\_\_  
Yes No Have you ever been told that you grind your teeth? \_\_\_\_\_  
Yes No Do you have "tension" headaches? \_\_\_\_\_  
Yes No Have you ever experienced chronic ringing in your ears? \_\_\_\_\_  
Yes No If the patient is under age 16, height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_  
Yes No Are you aware that some appointments will be during school/work hours? \_\_\_\_\_  
Please list some hobbies or interests \_\_\_\_\_  
Female Patients only:  
Yes No Are you pregnant? \_\_\_\_\_  
Yes No Has menstruation started? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only:

I verbally reviewed the medical/dental information with the patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_