

Welcome to Our Office!
Please take a few moments to fill out this information as completely as you can.

PATIENT INFORMATION

Date _____		Current Age _____	
Patient's Name _____			
Last	First	Middle	
Address _____			
Street	City	State	Zip
Home Phone _____	Cell _____	Birthdate _____	Social Security # _____
Family Dentist _____		Phone # _____	When last seen? _____
Is any dental work pending? _____ Please describe: _____			
Whom may we thank for referring you to our office? _____			

RESPONSIBLE PARTY INFORMATION

Father/Spouse/Self _____			
Last	First	Middle	
Home Address _____			
Street	city	state	zip
Home Phone _____		Cell Phone or Pager _____	
Work Phone _____		Birthdate _____	
		Social Security # _____	
Employer _____		Occupation _____	
Business Address _____			
Street	City	State	
Mother/Spouse _____			
Last	First	Middle	
Home Address _____			
Street	city	state	zip
Home Phone _____		Cell Phone or Pager _____	
Work Phone _____		Birthdate _____	
		Social Security # _____	
Employer _____		Occupation _____	
Business Address _____			
Street	City	State	Zip

INSURANCE INFORMATION

Policy Holder's Name _____		Soc. Sec. # _____	
Relationship to Patient _____		Date of Birth _____	
Address _____			
Street	city	state	zip
Insurance Company _____		Group # _____	
Ins. Co. Address _____		Ins. Co. Phone _____	
<small>If you have Dual coverage, complete below information:</small>			
Policy Holder's Name _____		Soc. Sec. # _____	
Relationship to Patient _____		Date of Birth _____	
Address _____			
Street	city	state	zip
Insurance Company _____		Group # _____	
Ins. Co. Address _____		Ins. Co. Phone _____	

Please continue to other side

MEDICAL HISTORY

Has the patient been treated for any of the following:

Diabetes..... <input type="checkbox"/>	Epilepsy..... <input type="checkbox"/>	Fainting or Dizziness..... <input type="checkbox"/>
Pneumonia..... <input type="checkbox"/>	Anemia..... <input type="checkbox"/>	Prolonged Bleeding..... <input type="checkbox"/>
Heart Trouble..... <input type="checkbox"/>	Asthma..... <input type="checkbox"/>	Nervous Disorders..... <input type="checkbox"/>
Rheumatic Fever..... <input type="checkbox"/>	Kidney Involvement..... <input type="checkbox"/>	Liver Involvement..... <input type="checkbox"/>
Bone Disorders..... <input type="checkbox"/>	Tuberculosis..... <input type="checkbox"/>	Endocrine Problems..... <input type="checkbox"/>

What concerns you most about your teeth? _____

List any drugs or medications now being taken _____

List any allergies or drug sensitivity _____

Has the patient reached puberty? Girls --- Has she started menstruation? ☐ Yes ☐ No
Boys --- Has his voice changed? ☐ Yes ☐ No

Have tonsils been removed?.....☐ Yes ☐ No
Have there been any injuries to the face, mouth, or teeth?.....☐ Yes ☐ No
Has the patient ever sucked a thumb or fingers? Until what age?.....☐ Yes ☐ No
Have you been informed of any missing or extra permanent teeth?.....☐ Yes ☐ No
Has an orthodontist been consulted previously?.....☐ Yes ☐ No
Has either parent had orthodontic treatment?.....☐ Yes ☐ No

Signature (parent if patient is a minor)