#1. CONFIDENTIAL PATIENT INFORMATION

Patient's Name ______________________________ Sex: M F
Last First Middle

Address ______________________________
Street City State Zip

Home/Cell Phone ______________________________ Birthdate ______________

Patient's dentist ______________ Date of last cleaning ______________

Whom may we thank for referring you to our office? ______________________________

Please list any family members who have had treatment in our office: ______________________________

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

Signature (Parent's signature if minor) ______________________________ Date ______________

If the patient is a minor, please skip to box #2 below. If YOU are the patient, please fill out the remainder of this box and skip to box #3 on the reverse. You DO NOT need to fill out box #2.

Email Address ______________________________ Marital Status S M D W

Employer ______________________________ Years at Current Employer __________

Years at Current Address __________ Social Security # ______________________________

#2. CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

If patient is a minor, with whom does the patient reside? ______________ Relationship ______________

Parent #1: Name ______________________________ Marital Status S M D W
Last First Middle

Home Address ______________________________
Street City State Zip

Years at this Address ______________ Email Address ______________________________

Home/Cell Phone ______________ Work Phone ______________

Employer ______________________________ Years at Current Employer __________

SSN ______________ Birthdate ______________ Relationship to Patient ______________

Parent #2: Name ______________________________ Marital Status S M D W
Last First Middle

Home Address ______________________________
Street City State Zip

Years at this Address ______________ Email Address ______________________________

Home/Cell Phone ______________ Work Phone ______________

Employer ______________________________ Years at Current Employer __________

SSN ______________ Birthdate ______________ Relationship to Patient ______________

#3. CONFIDENTIAL MEDICAL AND DENTAL HISTORY

Has the patient ever had any of the following medical problems?

Y	N	Abnormal bleeding	Y	N	Congenital heart defect	Y	N	Hepatitis
Y	N	Allergies to any drugs	Y	N	Convulsions/Epilepsy	Y	N	HIV/AIDS
Y	N	Allergy to latex	Y	N	Diabetes	Y	N	Kidney/Liver problems
Y	N	Any hospital stays	Y	N	Endocrine/Growth disorders	Y	N	Nickel allergy
Y	N	Any operations/surgery	Y	N	Handicaps/Disabilities	Y	N	Rheumatic/scarlet fever
Y	N	Asthma	Y	N	Hearing impairment	Y	N	Tonsils/adenoids removed
Y	N	Cancer	Y	N	Heart murmur	Y	N	Tuberculosis
Y	N	Chronic sinus problems	Y	N	Hemophilia/Blood disorders	Other____________________		

Has the patient ever been told to take an antibiotic prior to dental visits? Y N
Is the patient currently under the care of a physician for any medical problems? Y N

Please discuss any ***yes*** answers in the space provided: ____

____

Please describe the patient's current physical health: Good Fair Poor

Date of the patient's last physical ______________________ Physician ____________________________

Please list any drugs/medications the patient is taking: ____

____

Does the patient have any of the following habits?

Y	N	Clenching or grinding teeth	Y	N	Nursing bottle habit
Y	N	Lip sucking or biting	Y	N	Speech problems and/or speech therapy
Y	N	Mouth breathing	Y	N	Thumb or finger sucking
Y	N	Nail biting	Y	N	Tongue thrust
Y	N	Smoking			

What are the main concerns that you would like orthodontic treatment to address? ______________________

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Has the patient ever been evaluated or had orthodontic treatment before? Y N
Has the patient ever received an injury to the face, mouth, teeth, or chin? Y N
Has the patient been informed about any missing or extra permanent teeth? Y N
Has the patient ever had any pain, tenderness, and/or clicking in the temporomandibular joint (TMJ)? Y N

Please discuss ***yes*** answers to the above questions: ____

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Does the patient have good oral hygiene habits? Y N
Does the patient see a general dentist regularly for check-ups? Y N

Please make any other comments that you feel may be helpful ____________________________________

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I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in the patient's medical status.

____ ______________________ Rev. 12/7/17

Signature of Patient or Guardian Date