

First Name: _____

Last Name: _____

Wednesday, September 15, 2004

First Appointment:

Nickname: _____ Email: _____
 Patients Address: _____ Zip: _____ Telephone: _____
 Birthdate: _____ Age: _____ Sex: _____
 School/Employer: _____ Grade/Position: _____
 Interest/Sports _____

Primary Mother Father Step Parent Self Other (specify) _____
 Responsible Party: _____ DOB: _____
 Address: _____ Zip: _____ Telephone: _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____ Primary Party Email Address: _____

Secondary Mother Father Step Parent Self Other (specify) _____
 Responsible Party: _____ DOB: _____
 Address: _____ Zip: _____ Telephone: _____
 Employer/Address: _____ Telephone: _____
 Social Security Number: _____ Secondary Party Email Address: _____

How Did You Hear About Us? Dentist Patient Relative Acquaintance Other _____
 Whom May We Thank For Referring You To Us? _____ Present Dentist: _____
 Reason For Consultation: _____

Circle Yes or No for which the patient has a history:

ADD/ADHD	Y N	Bulimia	Y N	Downs Syndrome	Y N	Hepatitis	Y N	Painful chewing	Y N	Smoking/Tobacco	Y N
Aids	Y N	Cancer	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Speech problems	Y N
Allergies	Y N	Cerebral palsy	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	TMJ problems	Y N
Anemia	Y N	Chest pains	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tooth Grinding	Y N
Arthritis	Y N	Chronic neck pain	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Tuberculosis	Y N
Aspirin	Y N	Clicking of jaw	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Veneral Disease	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Sinusitis	Y N
Autoimmune	Y N	Diabetes	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N	Prosthetic Joints	Y N
Bone Disorders	Y N	Diet pill usage	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N	Bone Medication	Y N

Any disease, problems, or allergies not mentioned above? _____
 Current Medications? _____
 Females: Have you started Menstruating? _____ At what age? _____
 Have wisdom teeth been extracted? _____ Any face, mouth or teeth injuries? _____
 Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____
 When was your last dental cleaning and check up? _____ Have you had previous orthodontic treatment? _____
 Are there any missing or extra teeth? _____ Have the Tonsils and adenoids been removed? _____
 Any oral habits such as thumb-sucking or nail-biting? _____
 Names and Ages of Brothers & Sisters: _____

Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: _____ Telephone: _____
 Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____
 Policy Holders Birthdate: _____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____
 Name of Policy Holder: _____ Mother Father Step Parent Self Other (specify) _____
 Policy Holders Birthdate: _____

Signature: _____ Relationship To Patient: _____ Date: _____