



Welcome to our office and thank you for coming!

Please complete (or correct) all information.

PATIENT

Last Name		First Name	
Birth Date		Gender	

PRIMARY RESPONSIBLE PARTY

Mother Father Step-Mother Step-Father Other _____

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Carrier and Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	

SECONDARY RESPONSIBLE PARTY

Mother Father Step-Mother Step-Father Other _____

Last Name		First Name		Nickname	
Birth Date				Gender	
E-mail				Social Security #	
Mailing Address				Home Phone #	
Years at this address?		Own or Rent?		Carrier and Cell Phone #	
Employer				Work Phone #	
Occupation				# Years Employed	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed				
Dental Insurance Company				Ins. Phone #	
Insurance Address				Group/ID #	
How did you hear about us	Dentist Hygienist Acquaintance Family Other _____				
Whom may we thank you for referring you to us					
Please describe the primary orthodontic concern for you child					

DENTAL & MEDICAL HISTORY

Dentist's Name:	Phone #	
Frequency of dental checks: <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a year <input type="checkbox"/> Only if problems exists <input type="checkbox"/> Never		
Date of last visit: _____		
Does your child have any unfinished dental care?	<input type="checkbox"/> Yes - Please explain	
Is your child nervous about dental treatment?	<input type="checkbox"/> Yes - Please explain	
Is there any history of face or dental injuries?	<input type="checkbox"/> Yes - Please explain	
Is there any history of thumb or finger sucking?	<input type="checkbox"/> Yes Stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No When?
Have you consulted an orthodontist previously for you child?	<input type="checkbox"/> Yes Whom?	
Has your child had any previous orthodontic treatment?	<input type="checkbox"/> Yes With Whom?	

Please check if you child now has (or has had in the past) any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergy: Metal | <input type="checkbox"/> Cold Sores/Herpes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Allergy: Penicillin | <input type="checkbox"/> Developmental Disorder | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Allergy: Other _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Allergy: Seasonal | <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Organ Transplant |
| <input type="checkbox"/> Anemia / Bleeding | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Growth Disorder | <input type="checkbox"/> Osteoporosis |

Does your child smoke? Yes No How Much? _____

Females: Currently Pregnant? Yes No

Any disease, health problems, or allergies not mentioned above? _____

Current medications? _____

Signature: _____ Relationship to Patient: _____ Date: _____