



We ask that you fill out this form, in its entirety, to assist us in providing you with the best service possible.

## Patient Information

Date \_\_\_\_\_ Patient's Age \_\_\_\_\_

Patient's Name \_\_\_\_\_ Birthday \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Male  Female  
Last First MI D M Y

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ PC \_\_\_\_\_

Home Phone \_\_\_\_\_ Dentist's Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Occupation (optional) \_\_\_\_\_

Cell Phone \_\_\_\_\_ Whom may we thank for referring you?  Dentist  Friend  Family Member  
 Website  Other

Email \_\_\_\_\_ Family members seen by us \_\_\_\_\_  
Last First

Do you have a Facebook account?  Yes  No

## Parent Information (please complete if patient is under the age of 18)

Patient lives with:  Mother  Father  Both Parents  Other (please specify) \_\_\_\_\_

Person responsible for Account \_\_\_\_\_ Relation \_\_\_\_\_

Address (if different from the Patient) \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ PC \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

### Mother's Information:

Name \_\_\_\_\_

Address \_\_\_\_\_  
(if different from Patient)

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Email \_\_\_\_\_

### Father's Information:

Name \_\_\_\_\_

Address \_\_\_\_\_  
(if different from Patient)

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Email \_\_\_\_\_

## Insurance Information

Our office charges the patient/parent/guardian directly for all professional services rendered. We will complete the necessary forms, so that you can receive the reimbursement to which you are entitled under your policy.

Do you have Orthodontic Coverage?  Yes  No  Unsure

### Primary

Insurance company Name \_\_\_\_\_

Policy/Group/ID No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Member's name on policy \_\_\_\_\_

Birthdate \_\_\_\_\_

Name of Group/Policy Holder/Employer \_\_\_\_\_

Local No. \_\_\_\_\_

### Secondary

Insurance company Name \_\_\_\_\_

Policy/Group/ID No. \_\_\_\_\_ Certificate No. \_\_\_\_\_

Member's name on policy \_\_\_\_\_

Birthdate \_\_\_\_\_

Name of Group/Policy Holder/Employer \_\_\_\_\_

Local No. \_\_\_\_\_

## Dental History

Reason for consultation (chief concern) \_\_\_\_\_

Is the patient happy with his/her smile?  Yes  No If not, what would he/she change? \_\_\_\_\_

Has the patient ever had or been evaluated for orthodontic treatment?  Yes  No

Does the patient want treatment?  Yes  No  Unsure

Has the patient now or ever experienced problems with their jaw joints (TMJ)?  Yes  No

If yes please specify \_\_\_\_\_

Have there been any injuries to the face, mouth, teeth, chin?  Yes  No

If yes please explain \_\_\_\_\_

Has the patient had or presently have any of the following habits:

Thumb/finger sucking  Lip Biting  Snoring  Grinding  Clenching  Mouth Breathing

Speech Problems  Tongue Thrusting  Chewing/Eating Problems  Sinus Problems  Nail Biting

Does the patient see the dentist regularly?  Yes  No How often does the patient brush? \_\_\_\_\_

How often does the patient floss? \_\_\_\_\_

## Medical History

Physician's Name \_\_\_\_\_ Physician's Phone No. \_\_\_\_\_

Patient's current physical health is  Good  Fair Is the patient currently under the care of a Physician?  Yes  No

If yes please explain \_\_\_\_\_

Does the patient require antibiotics before dental treatment?  Yes  No If yes please explain \_\_\_\_\_

Is the patient taking any prescription/over the counter drugs?  Yes  No List all \_\_\_\_\_

Does the patient have any allergies?  Yes  No List all \_\_\_\_\_

Do you use tobacco? (smoking or chewing)  Yes  No For Women: Is the patient pregnant?  Yes  No  Unsure

**If patient is a minor:** Has puberty been reached? (Menstruation or Voice Change?)  Yes  No

DOES THE PATIENT HAVE NOW, OR EVER HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No
Anemia/Blood transfusion/ Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defect/ Mitral Valve Prolapse/ Pacemaker/Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Aids/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalized for any reason	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/ Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Colitis/Crohns	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis (type____)/ Herpes(oral.cold sores)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
						Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above please explain \_\_\_\_\_

Describe any other medical condition not listed \_\_\_\_\_

## Signature

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status.

\_\_\_\_\_  
Signature Patient/Parent/Guardian

\_\_\_\_\_  
Date