

PATIENT INFORMATION

Employer:___

RESPONSIBLE PARTY FOR ACCOUNT

Patient Name:	Name:
LAST FIRST MI	- LAST FIRST MI
Gender: Male □ Female □	Relationship to Patient:
Birthdate:/	Mother ☐ Father ☐ Step-Mother ☐ Step-Father [
	Guardian Daniel L
Home Address.	Address (If different than patient):
CITY STATE ZIP	CITY STATE ZIP
Primary Phone Number:	Primary Phone Number:
Name of School: Grade:	Social Security #:/
Please list any sports and or extracurricular activities including musical instruments played:	Birthdate:/
	PRIMARY DENTAL INSURANCE
Siblings (Names & Ages)	Insurance Co. Name:
PARENT/GUARDIAN INFORMATION MATERNAL	Insurance Co. Address:
Name:	
LAST FIRST MI	CITY STATE ZIP
Relationship to Patient:	Insurance Co. Phone:
Mother \square Step-Mother \square Guardian \square Other \square	Group #:
Marital Status: S□ M□ D□ W□ SO□	Member ID #:
Address (If different than patient):	Policy Holders Name:
	Relationship to Patient:
CITY STATE ZIP	Policy Holders SSN:/
Email:	Policy Holders Birthdate://
Primary Phone Number:	Employer:
Occupation:	CECONDARY DENTAL INCLIDANCE
Employer:	SECONDARY DENTAL INSURANCE
	Insurance Co. Name:
PARENT/GUARDIAN INFORMATION PATERNAL	Insurance Co. Address:
Name:	CITY STATE ZIP
	Insurance Co. Phone:
Relationship to Patient: Father □ Step-Father □ Guardian □ Other □	Group #:
·	Member ID #:
Marital Status: S □ M □ D □ W □ SO □	Policy Holders Name:
Address (If different than patient):	Relationship to Patient:
CITY STATE ZIP	Policy Holders SSN:/
Email:	Policy Holders Birthdate: //
Primary Phone Number:	Employer:
Occupation:	



DENTAL HISTORY

What was the date of their last visit:	General Dentist: Phone:
How did you hear about our practice? Advertisement Internet Family/Friend Dentist Other	What was the date of their last visit: / /
What are the main concerns that you would like orthodontotics to correct? What are the main concerns that you would like orthodontotics to correct? Has your child visited an orthodontist before? Yes No If yes, date/reason:	
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Have we treated other family members? If yes, please list their names: Has your child's Tonsils Adenoids been removed? Has your child ever experienced pain/discomfort in their jaw joint (TM3/TMD) Yes No If yes, please describe left/right or both. AM or PM: Does your child have any missing or extra permanent teeth? Yes No Has your child ever had injury to the following: (Select all that apply) Teeth Jaw Chin Please describe injury: Does your child have speech problems? Yes No If yes, reason: Do they currently or have they ever had any of the following habits: (Check all that apply) Clenching/Grinding teeth: Lip Sucking/Bitting: Thumb/Finger Sucking: Mouth Breathing: Tongue Thrusting: Nail Bitting: Chewing/Eating Problem: MEDICAL HISTORY Is your child currently under a physician's care? Yes No If yes, explain: Physician: Phone: What was the date of their last visit: / / Does your child have any allergies or sensitivities? (ie medication, latex, nickel, etc) Y N If yes, explain: Is your child taking any medications at this time? Yes No If yes, explain: Has puberty (males) or menstruation (females) begun? Yes No If yes, explain: Has your child had any serious illnesses or operations? Yes No If yes, explain: Has your child has ever had any of the following: Another of their last visition? Epilepy Hepatitis Radiation Treatment Thyroid Problems Another Radia	
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Nail Biting: Chewing/Eating Problem:	
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□ Artificial Joints □ Cough, Persistent □ Heart Murmur □ Liver Disease □ Shortness of Breath □ Venereal Disease □ Asthma □ Coughing Blood □ Heart Problems □ Mitral Valve Prolapse □ Stroke □ Other □ Blood Disease □ Diabetes □ Hemophilia □ Pacemaker □ Swelling of Feet or Ankles	
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AUTHORIZATION - PLEASE SIGN & DATE	E blood blocks
	AUTHORIZATION - PLEASE SIGN & DATE
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 of confidence and it is my responsibility to inform the office of any changes in my child's medical status. I hereby authorize the release of any information	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

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Signature:	Date: