Whom may we thank for referring you to our office? _____
Have we treated any of your family or friends? _____

Patient Information *(Please Print)*

Name _____ Gender _____ Date _____
First Middle Last

Birth Date _____ Age _____ School _____ Grade _____

Address _____ How Long? _____

City _____ State _____ Zip _____

Home Phone # _____ Cell #_____

In an emergency, we may contact: Name _____ *Phone #* _____

Medical History

Primary Care Physician _____ Date of last visit _____

Please list *all* medications patient is currently taking: _____

Known allergies: _____

Current medical treatment and past hospitalizations: _____

Does the patient have *any* other medical condition that we should be aware of? _____

If the patient is a female, what was the date of her first menstrual cycle? _____

(Woman) Is patient pregnant? ☐Yes ☐ No Taking birth control? ☐Yes ☐ No

Does patient have a history of *any* of the following?

□ Allergies	□ Blood Disease	□ Hearing Disorder	□ Rheumatic Fever
□ Anemia	□ High/Low Blood Pressure	□ Heart Murmur	□ Seizure Disorder
□ Arthritis or Rheumatism	□ Cancer	□ Hepatitis	□ Sleeping Disturbances
□ Artificial Heart Valves	□ Cough, persistent	□ HIV-Positive	□ Stroke
□ Asthma	□ Diabetes	□ Kidney Disease	□ Thyroid Problems
□ Auto-Immune Disorder	□ Dizziness/Fainting	□ Liver Disease	□ Tobacco Habit
□ Back Problems	□ Emotional Problems	□ Psychiatric Care	□ Tonsillitis

□ Other _____

If you checked *any* of the above please explain: _____

Additional Information

What dental problem brings this patient to my office? _____

Is the patient aware of the orthodontic problem? ☐Yes ☐ No

Patient's interest in orthodontic care: ☐Wants treatment ☐Treatment if necessary ☐Unwilling but agrees ☐ Minimal

Orthodontic consultation prompted by: ☐Patient ☐Dentist ☐Mother/Father ☐Physician ☐Friend ☐Other_____

What are some of your final treatment goals?

□Beautiful smile	□ Evenly aligned teeth	□ Healthy bite	□ Long term stability
□Ease of treatment	□ Improve facial proportions	□ Correct overbite	□ Eliminate crowding
□Close spaces	□ Improve facial appearance	□ Eliminate pain	□ Short treatment time

□Other_____

Is there anything in particular that you would like to change about your smile? _____

_____

Does patient have a history *any* of the following?

□ Previous orthodontic treatment	□ Bleeding gums	□ Speech problems	□Mouth sores
□ Mouth/Face injuries	□ Periodontal care	□ Difficulty Chewing	□ Chin scar
□ Thumb/Finger sucking	□ Mouth breather	□ Snores while sleeping	□Teeth grinding
□ Clicking/popping in jaw	□ Jaw pain	□ Pain around the ear /Earaches	□ Headaches

If you checked *any* of the above, please explain: _____

Patient's Dentist _____ How long/Often? _____

Responsible Billing Party (Legal Guardian present to accept assignment of fees, not necessarily the policy holder)

Name _____ SS# _____ DOB: _____
First Middle Last

Place of Employment _____ How Long? _____

Employer's address _____ City _____ State ___ Zip _____

Occupation _____ Work # _____ Cell #_____

Other Parent Name _____ SS# _____ DOB:_____
First Middle Last

Place of Employment _____ How Long? _____

Employer's address _____ City _____ State ___ Zip _____

Occupation _____ Work # _____ Cell #_____

Dental Insurance Information

Insurance Company _____ Policy Holder _____

Group # _____ ID # _____ Phone # _____

Address _____ City _____ State ___ Zip _____

Our preferred method of communicating is via email. What email address can we use for:

Account/Statements _____

Appointments _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The questions on both pages have been accurately answered. I understand that providing incorrect information can be dangerous to my dependent's health. I authorize the orthodontist to release any information including the diagnosis and records of any treatment or examination rendered to my dependents during the period of such dental care to third party payer and/or health practitioners. I understand this may include the release of information concerning HIV testing, diagnosis, or treatment of AIDS, AIDS related conditions, drug or alcohol abuse or related conditions, any psychiatric and/or psychological conditions. I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand that any balance carried on the house accounts after thirty (30) days from the date of service, will be charged interest on the unpaid balance at 1 ½ percent per month, compounded monthly, at an annual percentage rate of 18%. I understand that I am subject to credit checks before and/or during the course of treatment (includes new and current patients).

_____ _____

Signature of Patient or Parent if Patient is a Minor Date

Acknowledgement of receipt of notice of privacy practices

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Parent Date Signature of Patient Date