Confidential Patient Information

Today's Date ___/___/____

Patient's Name ____ Birth Date___/___/___ Age _____Sex______
Address ____ City_______________ Zip Code __________
Home Phone (________)_______________________________________ Email _______________________________
Patient's General Dentist _________________________ Phone # (_____)-_______________ City ______________
Whom may we thank for referring you to our office? ____
Please list other family members in treatment ____

Confidential Responsible Party Information

Name ____ Birth Date ___/___/___
Relation to Patient _______________________ Address ____
City ____________________________________ Zip Code __________________ Home Phone (___)- ________________
Work (_______)-___________________________ Social Security # ____-______-______
Employer ________________________________ Occupation ________________ No. Years Employed ______________
Spouse's Name ____ Birth date ____________
Relationship to Patient ____________________ Employer __________________ Work Phone (__)-________________
Occupation ____ No. Years Employed ______________

Insurance Information

Do you have orthodontic Insurance YES___ NO___

Primary Coverage
Subscribers Name ______________________________
Social Security #_____-______-______
Birth date ___/___/___ Employer________________
Name of Insurance Co.___________________________
Phone#(______)-____________ Group#_____________

Secondary Coverage
Subscribers Name ______________________________
Social Security #_____-______-______
Birth date ___/___/___ Employer ________________
Name of Insurance Co.___________________________
Phone#(______)- ___________Group#_____________

Dental History

Have there ever been injuries to the face, mouth, teeth or jaw?_______________________________________
Has there ever been a thumb or finger habit? ____
Are there any speech or articulation problems? ____
Has the child had prior orthodontic treatment? If so, When? ____
What is your main concern today? ____

Medical History

Is there a history of major illness? ____Please explain? ____
Has patient had any of the illnesses listed below? (please circle)

Diabetes	Anemia	Prolonged Bleeding	Asthma	Cancer	Heart Trouble
Hepatitis	TMD Disorder	Rheumatic Fever	Kidney Disease	AIDS/HIV	Bone Disorder
Tuberculosis	Stroke	Endocrine Problems	High Blood Pressure		

Emergency Contact

Name ______________________________________ Relationship_______________ Phone # (_____)_____________
This office reserves the right to verify credit status of potential patients seeking payment terms.

Signature ____ Date_________________

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