

INSURANCE INFORMATION

Coverage: Orthodontic: yes no

Insurance Company Name: _____ Insurance phone: _____

Insurance address: _____ City: _____ State: _____ ZIP _____

Identification number: _____ Group number: _____

Who is the primary policy holder? Parent Self Spouse Other

Name : _____
First MI Last Preferred Name

DOB: _____ SS# _____ Home/ Cell Phone number: _____

Medical: yes no

Insurance Company Name: _____ Insurance phone: _____

Insurance address: _____ City: _____ State: _____ ZIP _____

Identification number: _____ Group number: _____

Who is the primary policy holder? Self Spouse Other

Name : _____
First MI Last Preferred Name

DOB: _____ SS# _____ Home/ Cell Phone number: _____

DENTAL INFORMATION

Has the patient seen a general dentist in the last year? yes no

Any pain, clicking, or discomfort in or near the ears? yes no

Has the mouth, face, or teeth been injured by a fall or accident? Yes no

Are you aware of any "gum" problems? yes no

Have the patient's tonsils or adenoids been removed? yes no

Do you feel the patient can benefit from orthodontic treatment? yes no

Is the patient happy with their smile? yes no

Does the patient want to improve their smile and bite? yes no

Does the patient have or ever had any of the following habits? yes no

Cheek, tongue or lip chewing yes no Finger/thumb sucking yes no

Clenching teeth yes no Tongue thrusting yes no

Mouth breathing yes no Grind teeth yes no

Finger nail biting yes no Speech problems yes no

Has the patient been examined by an orthodontist before? yes no

If yes, when? _____

Have other members of the family had orthodontic treatment? yes no

If yes, were you happy with the results? yes no

If no, why: _____

In your own words, what is the chief orthodontic concern? _____

What would you like orthodontic treatment to accomplish? _____

MEDICAL INFORMATION

Is there a patient history of:

Frequent or severe headaches yes no
Heart Disease yes no
Sinus or respiratory disease yes no
Blood disease yes no
Liver disease yes no
Thyroid disease yes no
Kidney disease yes no
H.I.V. positive yes no
Venereal disease yes no
Intestinal disease yes no
Bone disease yes no
Nervous/emotional problems yes no
High or Low blood pressure yes no
Endocrine problems yes no
Problems with wounds healing yes no
Tumors or Cancer yes no
Tonsillitis / Sore throats often yes no
Joint problems yes no
Rheumatic/yellow/scarlet fever yes no
Acquired Immune Deficiency Syndrome yes no
Is patient under medical care? yes no
Is patient pregnant at this time? yes no
Measles/mumps/chicken pox yes no
Does patient smoke yes no
Fever Blisters yes no
Height and weight normal for age yes no
Is patient in good health? yes no
Has patient has a physical this year? yes no
Has patient reached puberty? yes no
If male, has patient begun to shave? yes no
If female, has patient begun menstruation? yes no
Anemia yes no
Hemophilia yes no
Emphysema yes no

Heart Murmur yes no
Polio yes no
Diabetic yes no
Epileptic yes no
Asthma/hay fever yes no
Tuberculosis yes no
Broken bones yes no
Rheumatism/arthritis yes no
Is patient taking medicine? yes no
Fainting/dizziness yes no
Drug addiction yes no
Yellow jaundice yes no
Radiation therapy yes no
Chemical therapy yes no
Blood transfusions yes no

Hepatitis

Hepatitis A yes no

Hepatitis B yes no

Hepatitis C yes no

other, please specify: _____

Any allergies or unusual reactions to

Aspirin yes no

Barbiturates yes no

Sulfa drugs yes no

Penicillin yes no

Latex yes no

Other: _____

List any other allergies or reactions: _____

List any medications currently taking: _____

Are you aware of any other disease condition or problem not listed above that we should know about? _____

Authorization

I understand that, where appropriate, credit bureau reports may be obtained.

Patient / Parent Signature: _____

Date: _____

Doctor Signature: _____

Date: _____