



PATIENT INFORMATION

PATIENT NAME				DATE	
LAST		FIRST	M.I.	PHONE #	
DATE OF BIRTH	,	AGE	SEX	REFERRED BY	
ADDRESS				DENTIST	
CITY		STATE	ZIP	ORAL SURGEON	
FAMILY MEMBERS PREVIOUSLY SEEN	٧			DOCTOR	
				EMERGENCY CONTACT _	
PERSON RESPONSIBLE FOR ACCOU	JNT			EMERGENCY PHONE #	
ADDRESS (IF DIFFERENT)					
CITY		STATE	ZIP		
PARENT INFORMATION (IF PA	ATIENT IS UND	PER THE AGE OF 18)			
FATHER'S NAME			MOTHER'S	NAME	
ADDRESS					
CITY				STATE	
PHONE #					
CELL PHONE #				NE #	
WORK PHONE #				ONE#	
SOCIAL SECURITY #				CURITY#	
DATE OF BIRTH			DATE OF BI	IRTH	
SUBSCRIBER NAME				R NAME	
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE #			PHONE # _		
RELATIONSHIP TO PATIENT			RELATIONS	SHIP TO PATIENT	
EMPLOYED BY			EMPLOYED	BY	
EMPLOYER ADDRESS				ADDRESS	
CITY	STATE	ZIP	CITY	STATE	ZIP
INSURANCE COMPANY			INSURANC	E COMPANY NAME	
ADDRESS					
CITY				STATE	
COMPANY PHONE #			COMPANY	PHONE #	
ID #					
GROUP #			GROUP # _		
I hereby authorize release of any i	TURE			DATE	
l hereby authorize payment direct	•	thodontics, S.C. of t	the insurance benefits o	. ,	
SIGNA	TURE			DATE	

PATIENT MEDICAL HISTORY

SIGNATURE

DIABETES

EPILEPSY

ANEMIA

CIRCLE ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

KIDNEY PROBLEMS

NERVOUS DISORDER

BONE DISORDER

RELATIONSHIP TO PATIENT

TUBERCULOSIS

LIVER PROBLEMS

ASTHMA

PROLONGED BLEEDING HEART TROUBLE HEART MURMUR MITRAL VALVE PROLAPSE RHEUMATIC FEVER HIGH BLOOD PRESSURE		AIDS/HIV	RANSFUSION POSITIVE INE PROBLEMS LERGY	TONSILLITIS FAINTING/DIZZINESS SINUS PROBLEMS JAW PAIN SURGICAL IMPLANT OTHER	
LIST ANY HISTOR	Y OF MAJOR ILLNESS				
	NT HAVE A TENDENCY TO? C		SORETHROATS NO WHAT AGE?	EAR INFECTIONS	
PLEASE LIST:	ALLERGIES OR DRUG SI	ENSITIVITIES	DRUGS OR N	MEDICATIONS BEING TAKEN	
PATIENT DEN			CAMUICUTUS PATISATUA	C EXPEDIENCED	
			G WHICH THE PATIENT HA		
	BAD BREATH		G OF TEETH		
BLEEDING GUMS			ntal disease R growths in mouth		
JAW CLICKING OR POPPING MISSING TEETH			TOOTH ERUPTION		
	CIRCLE ANY (OF THE FOLLOWIN	IG HABITS WHICH THE PAT	IENT MAY HAVE	
	FINGER/THUMB SUCKING		G/SUCKING	TONGUETHRUST	
MOUTH BREATHING		NAIL BITI		OTHER	
	CIRCLE ANY C	FTHE FOLLOWING	G WHICH ARE CONCERNS	OF THE PATIENT	
	CROWDING		SMILE	CLICKING JAW JOINT	
	SPACES		EASE/RECESSION	IRREGULARLY SHAPED TEETH	
	OVERBITE		ГЕЕТН	PROTRUSION OF TEETH	
	"BUCK TEETH"		UNCTION	HEADACHES/FACIAL PAIN	
	RECEDED JAW		OUTH	NECK PAIN	
	PROMINENT JAW	IRREGULA	AR FACIAL STRUCTURE	OTHER	
HOW OFTEN DO	YOU HAVE A DENTAL CHECKUP?	ONCE A YEAR	R TWICE A YEAR	ONLY IF URGENT NEVER	
HAVE YOU HAD A	A PREVIOUS ORTHODONTIC EXAM	OR TREATMENT?	YES	NO	
ISTHE PATIENT IN	NTERESTED IN ORTHODONTIC TRE	EATMENT?	YES	NO	
AREYOU AWARE	OF ANY ORTHODONTIC PROBLEM	15?	YES	NO	
	T HAD ANY INJURIES TO THE TEETH	, MOUTH OR JAWS	? YES	NO	
HAS THE PATIENT	I HAD ANT INJUNES TO THE TEETH	•			