Reviewed by:_____ **Date:**_____

Patient Name_____ Date of Birth_____ Male _____ Female _____

Address_____ Home Phone _____
street city state zip

Father_____ Address _____ DOB _____

Employer _____ Business Phone _____ Cell Phone _____

Mother _____ Address _____ DOB _____

Employer _____ Business Phone _____ Cell Phone _____

Who may we thank for referring you to our office? _____

Siblings in Treatment with us? Yes No Names and Ages:_____

Siblings in family? Yes No Names and Ages:_____

Insurance Information

Financially Responsible Party _____ Do you have orthodontic insurance? Y / N

Insurance Company _____ Phone # _____

Subscriber Name: _____ DOB: _____ Subscriber SS#:_____

Subscriber ID#: _____ Group # _____

Secondary Insurance? _____ Subscriber Name: _____ DOB _____
Insurance Company _____ Subscriber ID#: _____ Group # _____

Dental History

Dentist's Name: _____ **Frequency of visits:** _____ **Last visit:**_____

1. Have there been any injuries to the face, mouth, or teeth?_____ Explain:_____
2. Has the patient ever sucked a thumb or fingers?_____ Until what age?_____
3. Does the patient have any speech problems?_____
4. Is the patient a mouth breather?_____
5. Have you been informed of any missing or extra teeth?_____
6. Has an orthodontist been consulted previously?_____
7. Has either parent been treated orthodontically? _____ Mother _____ Father _____
8. List any musical instruments played_____
9. Has the patient ever had jaw pain_____, clicking_____, or locking in the jaw joint_____
10. Does the patient grind/clinch teeth?_____

Reason for orthodontic evaluation:_____

Medical History

Doctors Name: _____ Address:_____ Phone # _____

1. Is the patient in good health?_____ If NO, explain_____
2. Does the patient have a history of any serious or major illness? _____ Explain_____
3. Is the patient presently under medical care?_____ For what?_____
4. Does the patient have any allergies?____ Allergic to_____
5. Does the patient have a tendency to colds?_____ Sore throats?_____ Ear infections?_____
6. Have tonsils/adenoids been removed?_____ Age_____
7. **List any drugs or medication now being taken**:_____
8. WOMEN: Are you pregnant?_____
9. Check any of the following conditions that the patient has been or is being treated for:

Diabetes	_____	Tuberculosis	_____	Hormone problems	_____
Pneumonia	_____	Anemia	_____	Prolonged bleeding	_____
Heart Trouble	_____	Epilepsy	_____	Fainting or Dizziness	_____
Rheumatic Fever	_____	Asthma	_____	Nervous disorder	_____
Bone disorders	_____	Kidney problems	_____	Hepatitis	_____

I understand, where appropriate, a credit report will be obtained: _____

(Parent/Guardian Signature)