DATE:_______________________________________

PATIENT INFORMATION

PATIENT NAME____
LAST FIRST MIDDLE NICKNAME

ADDRESS____
STREET CITY STATE ZIP

HOME PHONE________________________________BIRTHDATE__________________________SS#______________________

IF PATIENT IS A MINOR, GIVE PARENT'S/GUARDIAN'S NAME____

FAMILY DENTIST____WHEN LAST SEEN__________________________________

IS ANY DENTAL WORK PENDING?____________PLEASE DESCRIBE____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

SIBLING/CHILDREN INFORMATION:

NAME____SEX____________DOB________________________

NAME____SEX____________DOB________________________

RESPONSIBLE PARTY INFORMATION

NAME____
LAST FIRST MIDDLE

EMAIL____MARITAL STATUS_________________________

RESIDENCE____
STREET CITY STATE ZIP

MAILING ADDRESS____
STREET CITY STATE ZIP

CELL PHONE___________________________HOME PHONE_______________________WORK PHONE_____________________

SOCIAL SECURITY #___________________________BIRTHDATE_____________________RELATIONSHIP TO PT______________

EMPLOYER_____________________________________OCCUPATION______________________# YRS EMPLOYED___________

SPOUSE'S NAME____RELATIONSHIP TO PT______________

EMPLOYER_____________________________________OCCUPATION______________________#YRS EMPLOYED___________

SOCIAL SECURITY #___________________________BIRTHDATE_____________________WORK PHONE___________________

DENTAL INSURANCE INFORMATION

INSURED'S NAME____INSURED'S MEMBER ID____________________________

INSURANCE COMPANY____________________________GROUP #________________________PHONE____________________

INSURANCE CO. ADDRESS____

INSURED'S EMPLOYER____

DO YOU HAVE DUAL COVERAGE? YES________NO________IF YES, PLEASE COMPLETE THE FOLLOWING:

INSURED'S NAME____INSURED'S MEMBER ID____________________________

INSURANCE COMPANY____________________________GROUP #________________________PHONE____________________

INSURANCE CO. ADDRESS____

EMERGENCY INFORMATION

EMERGENCY CONTACT____PHONE______________________________

COMPLETE ADDRESS____

I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

SIGNATURE____UPDATES (DATE & INITIAL)______________________

HEALTH STATUS

MAIN CONCERNS REGARDING THE JAWS AND TEETH____

PATIENT'S CURRENT PHYSICAL HEALTH____

PATIENT'S CURRENT MENTAL HEALTH____

ALL CURRENT MEDICATIONS TAKEN BY PATIENT____

MEDICAL HISTORY PLEASE PROVIDE AN EXPLANATION FOR ANY "YES" ANSWERS:

Y or N BLOOD DISORDERS (PROLONGED BLEEDING, ANEMIA, OTHER)?____

____

Y or N CIRCULATORY PROBLEMS (HIGH BLOOD PRESSURE, HEART MURMURS, ANTIBIOTIC PREMEDICATION, OTHER)?____________

____

Y or N IMMUNE PROBLEMS (AUTO IMMUNE, DIABETES, AIDS, OTHER)?____

____

Y or N AIRWAY PROBLEMS (MOUTH BREATHING, SNORING, SLEEP APNEA, ASTHMA, TONSILECTOMY, OTHER)?

____

Y or N ALLERGIES (LATEX, FOOD, DRUG, NICKEL, OTHER)?

____

Y or N COMMUNICABLE DISEASE (HIV, HEPATITIS, TUBERCULOSIS, OTHER)?____

DENTAL HISTORY PLEASE PROVIDE AN EXPLANATION FOR ANY "YES" ANSWERS:

Y or N SIGNIFICANT INJURY TO THE TEETH OR JAWS?____

Y or N GRIND/CLENCH THE TEETH?____

Y or N DIFFICULTY CHEWING?____

Y or N PAIN/CLICKING IN THE JAW JOINTS?____

Y or N TREATMENT FOR TMJ DISORDER?____

ORTHODONTIC HISTORY PLEASE PROVIDE AN EXPLANATION FOR ANY "YES" ANSWERS:

Y or N PREVIOUS ORTHODONTIC TREATMENT?____

Y or N CONCERNS ABOUT ORTHODONTIC TREATMENT?____

Y or N HABITS RELATED TO THE TEETH (NAIL BITING, FINGER HABIT, SMOKING, TOBACCO USE, OTHER)?_______________________

Y or N SPEECH DISORDERS/SPEECH THERAPY?____

SIGNATURE____**PRINT NAME**___________________________________

DATE____