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Patient Number

Date

PATIENT INFORMATION

Name: _____ (First / Mi / Last) D.O.B. _____ Age: _____ ❑ M ❑ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____ *Circle best contact option*

FATHER / GUARDIAN / SELF

Name: _____ (First / Mi / Last)

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ or ❑ Cell ❑ Work: Phone: _____

Birthday: _____ Age: ___ Sex: ____ Marital Status: _____

If there is Orthodontic Insurance Benefit, we need the following information filled out.

Social Security Number / ID#: _____

Group Number, if available: _____

Local or Union #: _____

Name of Employer: _____

Name of Insurance Company: _____

Insurance Co. Address: _____

City/State/Zip Code: _____

If Employed by Ford/GM: ❑ Salaried ❑ Hourly

MOTHER / GUARDIAN / SPOUSE

Name: _____ (First / Mi / Last)

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: _____ or ❑ Cell ❑ Work: Phone: _____

Birthday: _____ Age: ___ Sex: ____ Marital Status: _____

If there is Orthodontic Insurance Benefit, we need the following information filled out.

Social Security Number / ID#: _____

Group Number, if available: _____

Local or Union #: _____

Name of Employer: _____

Name of Insurance Company: _____

Insurance Co. Address: _____

City/State/Zip Code: _____

If Employed by Ford/GM: ❑ Salaried ❑ Hourly

Who is the responsible party: _____

Who may we thank for referring you? _____

Dentist's Name: _____

Address: _____

Phone: _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

Over →

MEDICAL INFORMATION - DO YOU HAVE OR HAVE YOU EVERY HAD...

Heart Disease: ❑ YES ❑ NO
Respiratory Disease: ❑ YES ❑ NO
Blood Disease: ❑ YES ❑ NO
Liver Disease: ❑ YES ❑ NO
Thyroid Disease: ❑ YES ❑ NO
H.I.V. Positive: ❑ YES ❑ NO
Venereal Disease: ❑ YES ❑ NO
Intestinal Disease: ❑ YES ❑ NO
Bone Disease: ❑ YES ❑ NO
Nervous/Emotional Disease: ❑ YES ❑ NO
ADHD ❑ YES ❑ NO
High or Low Blood Disease: ❑ YES ❑ NO
Endocrine Problems: ❑ YES ❑ NO
Renal/Kidney Disease: ❑ YES ❑ NO
Problems with Wounds Healing: ❑ YES ❑ NO
Tumors or Cancer: ❑ YES ❑ NO
Rheumatic/Yellow/Scarlet Fever: ❑ YES ❑ NO
Acquired Immune Deficiency Syndrome (AIDS): ❑ YES ❑ NO
Is Patient Under Medical Care: ❑ YES ❑ NO
A History of Fainting or Dizziness: ❑ YES ❑ NO
A Drug Addiction: ❑ YES ❑ NO
Is the Patient Pregnant at this Time: ❑ YES ❑ NO
Measles/Mumps/Chicken Pox: ❑ YES ❑ NO
Does the Patient Smoke: ❑ YES ❑ NO
Is the Patient in Good Health: ❑ YES ❑ NO
Is Height and Weight Normal for Age: ❑ YES ❑ NO
Fever Blisters: ❑ YES ❑ NO
Has the Patient Had a Physical this Year: ❑ YES ❑ NO
Has the Patient Reached Puberty: ❑ YES ❑ NO

Heart Murmur: ❑ YES ❑ NO
Premedicate: ❑ YES ❑ NO
Hepatitis: ❑ YES ❑ NO
Type A ✓ B C (circle)
Diabetes: ❑ YES ❑ NO
Anemia: ❑ YES ❑ NO
Hemophilia: ❑ YES ❑ NO
Emphysema: ❑ YES ❑ NO
Mononucleosis: ❑ YES ❑ NO
Asthma: ❑ YES ❑ NO

Polio: ❑ YES ❑ NO
Tuberculosis: ❑ YES ❑ NO
Any Broken Bones: ❑ YES ❑ NO
Prolonged Bleeding: ❑ YES ❑ NO
Yellow Jaundice: ❑ YES ❑ NO
Radiation Therapy: ❑ YES ❑ NO
Chemical Therapy: ❑ YES ❑ NO
Blood Transfusions: ❑ YES ❑ NO
Latex Allergy: ❑ YES ❑ NO
Hay Fever: ❑ YES ❑ NO

Is the Patient Allergic to Anything? ❑ YES ❑ NO
If yes, explain: _____

List Any Medications Being Taken: _____

Are you aware of Any Other Disease, Condition, or Problem not listed above that We Should Know About? _____

Are immunizations up to date? ❑ YES ❑ NO

DENTAL HISTORY

Has the Patient Seen a General Dentist in the Last Year: ❑ YES ❑ NO
Any Pain, Clicking or Discomfort In or Near the Ear: ❑ YES ❑ NO
Has the Mouth, Face or Teeth Been Injured by a Fall or Accident: ❑ YES ❑ NO
Have You Been Informed of Missing or Extra Permanent Teeth: ❑ YES ❑ NO
Are You aware of Any "Gum" Problems: ❑ YES ❑ NO
Has a Physician or Dentist Advised Antibiotics Before Dental Exam: ❑ 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 His/Her "SMILE": ❑ YES ❑ NO
Does the Patient Want to Improve His/Her "SMILE" and "BITE": ❑ YES ❑ NO
Would the Patient Mind Wearing "BRACES" ❑ YES ❑ NO
Are you allergic to any metals or dental materials ❑ YES ❑ NO

Does the Patient Have or Ever Had Any of the Following Habits:
Gag Reflex ❑ YES ❑ NO
Cheek, Tongue or Lip Chewing ❑ YES ❑ NO
Thumb Sucking: ❑ present ❑ past ❑ YES ❑ NO
Mouth Breathing: ❑ YES ❑ NO
Finger Nail Biting: ❑ YES ❑ NO
Clenching Teeth: ❑ YES ❑ NO
Tongue Thrusting: ❑ YES ❑ NO
Grinding Teeth: ❑ YES ❑ NO
Speech Problems: ❑ YES ❑ NO
Has the Patient Been Examined by an Orthodontist Before: ❑ YES ❑ NO
If yes, when: _____
Is this a second opinion? ❑ YES ❑ NO
Have other Members of the Family had Orthodontic Treatment: ❑ YES ❑ NO
If yes, were you happy with the results: _____
If no, why: _____

In your own words, What Is The Orthodontic Problem: _____

What Would You Like Orthodontic Treatment To Accomplish? _____

Patient Signature _____ Date _____ Parent Signature _____

Submit Form