Patient Information Form

Welcome to our office! Please fill out the front and back of this form.

Patient Information

Patient's First and Last Name:_____ Date:_____

Patient's Preferred Name:_____ Birthdate: _____ Age:_____ Sex:_____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

If a minor, parents/guardians' names:_____Whom may we thank for referring you?_____

School:_____ General Dentist:_____ Physician:_____

Siblings' or Children's Names & Ages:_____

Have you ever been examined by an orthodontist?_____ If yes, when?_____ Had braces?_____

What are your primary concerns re: your smile and bite?_____

When was your last teeth cleaning and exam with your dentist?_____

Medical History

Does patient have any history of major illness (check all that apply below)? Yes ❑ No ❑

Heart Complications	❑	Emphysema	❑	Veneral Disease	❑	Pneumonia	❑
High Blood Pressure	❑	Tuberculosis	❑	A.I.D.S.	❑	Psychiatric/Psychological Care	❑
Low Blood Pressure	❑	Asthma	❑	H.I.V. Positive	❑	Bone Disorders	❑
Rheumatic Fever	❑	Latex Sensitivity	❑	Blood Transfusion	❑	Herpes/Cold Sores	❑
Arthritis/Rheumatism	❑	Allergies	❑	Anemia	❑	Hemophilia/Prolonged Bleeding	❑
Kidney Complications	❑	Sinus Trouble	❑	Neurological Disorders	❑	Periodontal Disease	❑
Ulcers	❑	Cancer	❑	Epilepsy or Seizures	❑	Endocrine Problems	❑
Hepatitis A (Infectious)	❑	Diabetes	❑	Fainting or Dizzy Spells	❑	Liver Involvement	❑
Hepatitis B (Serum)	❑	Hypoglycemia	❑	Thyroid Problems	❑	Other:_____	❑

Does the patient have a tendency to colds? Yes ❑ No ❑ Sore Throats? Yes ❑ No ❑ Ear Infections? Yes ❑ No ❑

Have tonsils and adenoids been removed? Yes ❑ No ❑ At what age?_____

List any drugs or medications now being taken and give reasons:_____

List any allergies or drug sensitivity:_____

Dental History

Has the patient ever had any injuries to the face, mouth, or teeth? Yes ❑ No ❑

If yes, please explain:_____

Have you been informed of any missing or extra permanent teeth? Yes ❑ No ❑

Habits:	Nail/Lip Biting	Yes ❑	No ❑	Thumb or Finger Sucking	Yes ❑	No ❑
	Mouth Breathing	Yes ❑	No ❑	Grinding or Clenching of Teeth	Yes ❑	No ❑

Financially Responsible Party Information

❑ Ms. ❑ Mrs. ❑ Dr. ❑ Mr. ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed
First and Last Name:_____
Address/Phone: ❑ Same as patient's
❑ Different than patient's:_____ City:_____
State:_____ Zip:_____ Phone:_____
Social Security #:_____ Birthdate:_____ Relationship to Patient:_____
Employer:_____ Occupation:_____ # Years Employed:_____
Spouse's Name:_____ Birthdate:_____ Relationship to Patient:_____
Employer:_____ Occupation:_____ # Years Employed:_____
Social Security #:_____ Work Phone:_____

Insurance Information – *skip this section if you do not have orthodontic insurance*

Do you have orthodontic coverage? Yes ❑ No ❑ Benefit Amount: $_____ If no, skip this section.
*Insured's Name:_____ *Insured's DOB:____ *Social Security or ID #:_____
*Insured's Employer:_____Group #:_____
Insured's Employer Address:_____ City:_____ Zip:_____
*Insurance Company Name:_____ *Insurance Company Phone:_____
Insurance Company Address:_____ City:_____ Zip:_____
Secondary insurance? Yes ❑ No ❑ Benefit Amount: $_____ If no, skip this section.
*Insured's Name:_____ *Insured's DOB:____ *Social Security or ID #:_____
*Insured's Employer:_____Group #:_____
Insured's Employer Address:_____ City:_____ Zip:_____
*Insurance Company Name:_____ *Insurance Company Phone:_____
Insurance Company Address:_____ City:_____ Zip:_____
*** = *mandatory to process benefits***

Please read and sign if you have orthodontic insurance benefits:
I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity should I begin active treatment.
Signature (Parent's signature if minor):_____ Date:_____

Emergency Contact Information

Name of nearest relative not living with you:_____
Address:_____ City:_____ Zip:_____
Phone:_____ Relationship to Patient:_____

All patients/parents sign here to verify accuracy of patient information:

Signature (Parent's signature if minor):_____ Date:_____

Updates:

Patient/parent reviewed and made any applicable changes on the following dates:

_____	_____	_____	_____
Date/Initials	Date/Initials	Date/Initials	Date/Initials
_____	_____	_____	_____
Date/Initials	Date/Initials	Date/Initials	Date/Initials