



In order that we may know you better, please answer the following questions as completely as possible – Thanks.

Personal

Date _____
Patient's Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Email _____
Birthdate _____ Age _____
Social Security # _____
Drivers Lic. # _____
Hobbies/Interests _____
Children _____ Ages _____
Employer _____
Employer Address _____
Occupation _____
Work Phone _____
Spouse's Name _____

Responsible Party Information (if different)

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Social Security # _____ Birthdate _____
Relationship to Patient _____
Employer _____
Occupation _____

I understand that where appropriate, credit bureau reports may be obtained.

Date _____
Signature _____

Dental Insurance Information

Insured's Name _____
Insured's Home # _____ Work# _____
Insured's D.O.B. _____
Insured's Social Security # _____
Insurance Company _____
Group # _____ Insur. Co. Phone# _____
Insurance Co. Address _____
City _____ State _____ Zip _____

Medical/Dental History

Family Dentist _____
Date of last dental exam _____
Primary concern regarding tooth alignment?

Have you received previous Orthodontic Treatment?
 No Yes Dr. Name _____
Age _____
Is another member of your family/relative a patient at our office? No Yes
Name _____
Who may we thank for referring you to our office?

Habits: Thumb/Finger Sucking No Yes
Grinding/Clenching Teeth No Yes
Mouth Breathing No Yes
Lip/Cheek Biting No Yes

Speech Problem No Yes
What Sounds? _____

Jaw Joint Noise or Discomfort
 No Yes - see receptionist

Injuries to head, face or teeth? _____

Name of Physician _____

Check any of the medical conditions, which apply:
 Asthma Heart Problems Hepatitis
 Chronic Sinus Rheumatic Fever Diabetes
 Freq. Colds Blood Disease Seizures
 Freq. Headaches A.I.D.S. Hormonal Problems

Other physical or mental considerations? _____

Osteoporosis Medication being taken? _____

Other Drugs or Medications being taken/reasons? _____

Drugs or Allergy sensitivity _____