Patient information

Patient's Name_____ Date:_____

Preferred Name: _____ Birthday: _____ Sex: M / F

Best Phone #: _____ Contact Email: _____

Cell Phone Carrier: _____ (Allows us to send appointment reminders through text)

How do you prefer to receive appointment reminders? (Circle all that apply): Phone Text Email

Relatives treated at our office: _____

How did you hear about our office?: My Dentist Referred Me A Friend (Who?): _____

Facebook/Instagram Google/Internet My Insurance Plan Other: _____

If patient is an ADULT, please fill out this section:

Home Address: _____ Zip Code:_____

Employed by: _____ Phone: _____

Spouse's Full Name: _____ Employed by: _____

If patient is a MINOR, please fill out this section:

School: _____ Grade:_____

Father's Name: _____ Mother's Name: _____

Parents' Marital Status: Single Married Divorced Patient lives with:_____

Home Address: _____ City: _____State: _____ Zip: _____

Father's Employer:_____ Cell Phone #:_____

Mother's Employer: _____ Cell Phone #:_____

Is there any dental insurance we can check for you? ___ yes ___ no

Policy Holder Name: _____ Insurance Company: _____

Group No.: _____ ID: _____ Phone #: _____

Birthday: _____ Insured Social Security #: _____

Employer: _____ Occupation: _____

Dental history

Dentist: _____ Date of last visit: _____
What concerns you most about your teeth? _____

_____

Yes No Have you ever lost or chipped any permanent teeth? _____

Yes No Do you have any type of thumb or tongue habit?_____

Yes No Are you a mouth breather?_____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Medical history

Physician: _____ Date of Last Visit:_____

Please circle Yes or No (If Yes, please explain). Parents/Guardians please respond for minors.

Yes No Are you taking any medications?_____

Yes No Do you have any allergies (including Latex or Nickel)?_ _____

Yes No Do you have a history of a major illness/operation? _____

Yes No Does your physician recommend pre-medicating with antibiotics?_____

Yes No Female Patients only: Are you pregnant? _____

Yes No Are there any medical conditions we have not discussed that you feel we should be aware of?_____

Circle any of the medical conditions below that you have had or currently have:

Abnormal bleeding/Hemophilia	Epilepsy	Kidney problems
Anemia	Gastrointestinal Disorders	Nervous Disorders
Arthritis	Heart Problems	Pneumonia
Asthma or Hayfever	Hepatitis/Liver problems	Radiation/Chemotherapy
Bone Disorders	Herpes	Rheumatic Fever
Congenital Heart Defect	High Blood Pressure	Tuberculosis
Diabetes	HIV/AIDS	Tumor or Cancer

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the medical or dental history, I will so inform this practice.
Signature: _____Date: _____