***NAME*:**_____ Date: _____

First Middle Last Appointment Date: _____

Nickname/Preferred: _____

Patient's Address: _____ City:_____ State: _____ Zip: _____ Telephone: _____

Birthdate: _____ Age: _____ Sex: _____ Email:_____

School/ Employer: _____ Grade/ Position: _____

Interest/ Sports _____

Primary Mother Father Step Parent Self Other (Specify) _____

Responsible Party: _____ Telephone: _____

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

Employer Name/ Address:_____ Telephone_____ How Long: _____

Social Security Number: _____ Date of Birth: _____ Insurance Y/ N

Secondary Mother Father Step Parent Self Other (Specify) _____

Responsible Party: _____ Telephone: _____

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

Employer Name/ Address:_____ Telephone_____ How Long: _____

Social Security Number: _____ Date of Birth: _____ Insurance Y/ N

Insurance Information ***(We file private insurance. CHIPS will be submitted for approval. We do not accept Medicaid)***

Name of *Primary* Orthodontic Insurance Company: _____ Telephone _____

Name of Policy Holder/ Subscriber: _____ Mother Father Step Parent Self Other (Specify) _____

Name of Policy Holder Employer: _____ Policy Holder Date of Birth: _____

Policy HolderSocial Security # _____ Policy Holder ID Number if different from Soc Sec # _____

Name of *Secondary* Orthodontic Insurance Company: _____ Telephone _____

Name of Policy Holder/ Subscriber: _____ Mother Father Step Parent Self Other (Specify) _____

Name of Policy Holder Employer: _____ Policy Holder Date of Birth: _____

Policy HolderSocial Security # _____ Policy Holder ID Number if different from Soc Sec # _____

How did you hear about us? Dentist Patient Relative Acquaintance Other _____

Whom May We Thank For Referring You To us? _____ Present Dentist: _____

Reason for Consultation: _____

Medical History Circle Yes or No for which the patient has history:

Aids	Y	N	Cancer	Y	N	Endocrine problems	Y	N	Immune Problems	Y	N	Pneumonia	Y	N	Tooth Grinding	Y	N				
Allergies	Y	N	Cerebral Palsy	Y	N	Emotional Disorders	Y	N	Kidney Problems	Y	N	Pregnant	Y	N	Tuberculosis	Y	N				
Anemia	Y	N	Chest Pains	Y	N	Epilepsy	Y	N	Low Blood Pressure	Y	N	Prolonged Bleeding	Y	N	Veneral Disease	Y	N				
Arthritis	Y	N	Chronic Neck Pain	Y	N	Fainting/Dizziness	Y	N	Mouth Breathing	Y	N	Rheumatic Fever	Y	N		Y	N				
Aspirin	Y	N	Clicking of jaw	Y	N	Glaucoma	Y	N	Muscular Disorders	Y	N	Scoliosis	Y	N							
Asthma	Y	N	Cold Sores/ Herpes	Y	N	Headaches	Y	N	Nervous Disorders	Y	N	Seizures	Y	N							
Autoimmune	Y	N	Diabetes	Y	N	Heart Condition	Y	N	Organ Transplant	Y	N	Sicca	Y	N							
Bone Disorders	Y	N	Downs Syndrome	Y	N	Hepatitis	Y	N	Painful Chewing	Y	N	Speech Problems	Y	N							
Bulimia	Y	N	Drug Allergies	Y	N	High Blood Pressure	Y	N	Periodontal Problems	Y	N	TMJ Problems	Y	N							

Any Disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Females: Have you started Menstruating? _____ At what Age? _____

Have Wisdom teeth been extracted? _____ Any Face, Mouth, Teeth Injuries? _____

Does the patient normally breathe through the mouth while awake or asleep? _____ Do gums bleed when brushed or flossed? _____

Has an orthodontist been consulted previously? _____ Have you had previous orthodontic treatment? _____

Are there any missing or extra teeth? _____ Have the tonsils and adenoids been removed? _____

Any other questions? _____

Names and Ages of Brothers and Sisters: _____

Signature: _____ Relationship to patient:_____ Date: _____