

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date _____ Male _____ Female _____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname _____ Birthdate _____ Social Security # _____

School _____ Sports/Hobbies _____

*Parent or guardian name _____

*Siblings/ages _____

*Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address? _____ Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Marital Status: Single__ Married__ Widowed__ Separated__ Divorced__

Spouse Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. years employed _____

Social Security # _____ Birthdate _____ Work Phone _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

FOR OFFICE USE: TREATMENT COMMENTS

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____
Please circle Yes or No (If Yes, please fill in details)

- Yes No Is the patient taking any medication? _____
- Yes No Is the patient allergic to any medication? _____
- Yes No History of a major illness? _____
- Yes No Has the patient had any operations? _____
- Yes No Ever been involved in a serious accident? _____
- Yes No Have seen a physician in the last 12 months? Why? _____
- Yes No Has puberty begun? _____

Female Patients only: _____

- Yes No Has menstruation started? _____
- Yes No Is the patient pregnant? _____

Circle any of the medical conditions below that the patient has had or currently has.

- | | | | |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes | Hepatitis/Liver problems | Pneumonia |
| Anemia | Dizziness | Herpes | Prolonged Bleeding |
| Arthritis | Epilepsy | High Blood Pressure | Radiation/Chemotherapy |
| Asthma or Hayfever | Gastrointestinal Disorders | HIV / Aids | Rheumatic Fever |
| Bone Disorders | Heart Problems | Kidney problems | Tuberculosis |
| Congenital Heart Defect | Heart Murmur | Nervous Disorders | Tumor or Cancer |
- Are there any medical conditions we have not discussed that you feel we should be aware of? _____

DENTAL HISTORY

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

- Yes No Ever experienced any unfavorable reaction to dentistry? _____
- Yes No Have there been any injuries to face, mouth, or teeth? _____
- Yes No Do gums bleed when brushing? _____
- Yes No Any type of thumb or tongue habit? _____
- Yes No Is the patient a mouth breather? _____
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
- Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
- Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about the result? _____
- Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
- Yes No Experience jaw clicking or popping? _____
- Yes No Aware of clenching or grinding teeth? _____
- Yes No Does the patient need extra help with instructions? _____
- Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
- Yes No Are you aware that some appointments will be during school hours? _____
- *Yes No Any allergy to latex, metal/nickel or plastics? _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

AUTHORIZATION

This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one of more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurances does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. And I assign directly to the doctor all insurance benefits otherwise payable to me. I further authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ Date: _____

OFFICE USE ONLY

I have verbally reviewed the medical/dental information with the patient named herein.

Signature: _____ Date: _____