



Today's Date: _____

PATIENT INFORMATION

Name: _____ Nickname: _____ Sex: M or F SS# _____
 Address: _____ City, State, Zip: _____ Date of Birth: _____ Age: _____
 Home Phone: _____ General Dentist: _____ Last Visit: _____
 Employer: _____ Work Phone: _____
 Whom may we thank for this referral? _____
 What is your chief orthodontic concern? _____

RESPONSIBLE PARTY INFORMATION

Patient's marital status: Single _____ Married _____ Widowed _____ Divorced _____ Separated _____

Person responsible for account (if other than above) _____ Date of Birth: ____/____/____
 Address: _____ City, State, Zip: _____
 No. of years at this address? _____ Previous address (if less than 3 yrs.) _____
 Work #: _____ Cell Phone #: _____ Home #: _____
 Employer: _____ No. of years Employed: _____
 Occupation: _____ SS#: _____

Insurance Company: _____ Orthodontic coverage? Yes _____ No _____
 Policy Owner: _____ Group Number: _____
 Employer: _____ Address: _____

If Married:
 Spouse's Name: _____ SS#: _____
 Spouse's Employer: _____ No. years Employed: _____
 Occupation: _____ Work Phone #: _____

MEDICAL HISTORY INFORMATION

Physician: _____ Last visit date: _____
 Are you currently under the care of a physician? Yes _____ No _____
 Please describe your current physical health: Good _____ Fair _____ Poor _____
 Please list all drugs that you are currently taking: _____
 Please list all drugs that you are allergic to: _____

Have you ever had any of the following medical problems?

Yes _____ No _____ Abnormal bleeding	Yes _____ No _____ Hearing Impairment	Yes _____ No _____ Rheumatic/Scarlet Fever
Yes _____ No _____ Allergies to any Drugs	Yes _____ No _____ Heart Murmur	Yes _____ No _____ Diabetes
Yes _____ No _____ Hepatitis	Yes _____ No _____ Tuberculosis (TB)	Yes _____ No _____ Congenital/Heart Defect
Yes _____ No _____ Hives/Skin Rash	Yes _____ No _____ Asthma	Yes _____ No _____ Handicaps/Disabilities
Yes _____ No _____ HIV+/AIDS	Yes _____ No _____ Convulsions/Epilepsy	Yes _____ No _____ Any Operations, If Yes,
Yes _____ No _____ Herpes	Yes _____ No _____ Latex Allergies	
Yes _____ No _____ Exposed to HIV, but Negative		Please Explain: _____

Please discuss any serious medical problems you have had: _____
