Today's Date _____ Ins Type _____ NT _____ RCS _____ Patient # _____

PATIENT INFORMATION

Patient's Name _____ (_____) Birthdate _____ Sex M F
LAST FIRST MI PREFERRED NAME AGE

Address _____ Phone (_____)_____
STREET CITY STATE ZIP

If Patient is a minor, name of person(s) with Patient at exam _____ Relationship to Patient _____

Have we previously treated any other family member? YES NO If yes, who? _____

Has Patient seen another Orthodontist? YES NO If yes, who? _____

How did you learn of our orthodontic office?

Dentist Family Member Website Sign/Location Yellow Pages

Friend/Neighbor _____ Other _____

ACCOUNT INFORMATION

If Patient is a Minor:

Custodial Parent/Legal Guardian _____

Address _____
STREET CITY STATE ZIP

Father's Daytime Phone/Cell _____ Employer _____

Mother's Daytime Phone/Cell _____ Employer _____

E-Mail address _____

Is Patient covered by orthodontic insurance? YES NO If yes, name of plan _____

If Patient is an Adult:

Employer _____ Occupation _____

Daytime Phone/Cell _____ E-Mail address _____

Is Patient covered by orthodontic insurance? YES NO If yes, name of plan _____

MEDICAL/DENTAL HISTORY

Family Dentist _____ Address _____ Date of last dental visit _____

Is the Patient under a physician's care? YES NO If yes, for what? _____

List any medications now being taken _____ For what reason? _____

List allergies to any medications _____

Has the Patient been diagnosed or treated for any of the following? Indicate by circling Yes or No:

Rheumatic Fever	Y N	Anemia	Y N	Lung Disorders	Y N	Cancer	Y N	Osteoporosis	Y N
Heart Disease	Y N	Other Blood Disorders	Y N	Asthma	Y N	Seizures	Y N	Other Bone Disorders	Y N
Abnormal Blood Pressure	Y N	Hepatitis	Y N	Diabetes	Y N	Arthritis	Y N	Tuberculosis	Y N
Heart Murmur	Y N	AIDS/HIV Pos.	Y N	Other _____					

Does the Patient require medication before dental visits?	YES	NO	
Does the Patient have a latex allergy?	YES	NO	
Does the Patient have a persistent thumb or finger habit?	YES	NO	
Is the Patient a mouth-breather?	YES	NO	
Does the Patient vomit, gag, or faint easily?	YES	NO	
Does the Patient experience headaches or neck aches, especially under stress?	YES	NO	SOMETIMES
Does the Patient grind or clench the teeth?	YES	NO	SOMETIMES
Has the Patient had any injuries involving the jaw or teeth?	YES	NO	
Has the Patient experienced any pain, popping or locking of the jaw?	YES	NO	
Has the Patient ever been evaluated regarding a jaw problem?	YES	NO	
Has the Patient been treated for periodontal disease or has treatment been recommended?	YES	NO	
Is Patient/Parent aware that appointments will infringe on work/school?	YES	NO	

SIGNATURE _____ **DATE** _____
Patient (If Minor, Custodial Parent/Legal Guardian)

GDI No. 25823 9/2010

DR. INITIALS _____ **DATE** _____