



Personal Information

Patients Name _____ Nickname _____
Address _____ City _____ Zip _____
Home Phone _____ Birthdate _____ Age _____
School _____ Hobbies _____
Who may we thank for referring you? _____

Parents Information

Father _____ Birthdate _____ Mother _____ Birthdate _____
Address _____ Address _____
City/Zip _____ City/Zip _____
Home Phone _____ Cell _____ Home Phone _____ Cell _____
Email _____ Email _____
Employer _____ Employer _____
Address _____ Address _____
City/Zip _____ City/Zip _____
Work Phone _____ Work Phone _____

Insurance Information

Person(s) Financially Responsible _____ Phone _____
Do you have dental insurance? _____ If Yes, Name of Insurance Company _____
Insured Social Security # _____ Insured Birthdate _____

Medical History

Dentist _____ Physician _____

- | | | |
|--|---|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO DIABETES | <input type="checkbox"/> YES <input type="checkbox"/> NO ANEMIA | <input type="checkbox"/> YES <input type="checkbox"/> NO PROLONGED BLEEDING |
| <input type="checkbox"/> YES <input type="checkbox"/> NO PNEUMONIA | <input type="checkbox"/> YES <input type="checkbox"/> NO EPILEPSY | <input type="checkbox"/> YES <input type="checkbox"/> NO FAINTING/DIZZINESS |
| <input type="checkbox"/> YES <input type="checkbox"/> NO HEART TROUBLE | <input type="checkbox"/> YES <input type="checkbox"/> NO ASTHMA | <input type="checkbox"/> YES <input type="checkbox"/> NO NERVOUS DISORDERS |
| <input type="checkbox"/> YES <input type="checkbox"/> NO RHEUMATIC FEVER | <input type="checkbox"/> YES <input type="checkbox"/> NO KIDNEY INVOLVEMENT | <input type="checkbox"/> YES <input type="checkbox"/> NO LIVER INVOLVEMENT |
| <input type="checkbox"/> YES <input type="checkbox"/> NO BONE DISORDERS | <input type="checkbox"/> YES <input type="checkbox"/> NO TUBERCULOSIS | <input type="checkbox"/> YES <input type="checkbox"/> NO ENDOCRINE PROBLEMS |
| <input type="checkbox"/> YES <input type="checkbox"/> NO HEPATITIS | <input type="checkbox"/> YES <input type="checkbox"/> NO GLAUCOMA | <input type="checkbox"/> YES <input type="checkbox"/> NO HIV/AIDS |

List any drugs or medications now being taken _____

History of Allergies or Drug Sensitivity _____

Dental History

Have there been any injuries to the face, mouth, or teeth? _____

Has patient ever sucked a thumb or fingers? Until what age? _____

Have you been informed of any missing or extra permanent teeth? _____

Is the patient a mouth breather? _____ Awake or Asleep? _____

Has an orthodontist been consulted previously? _____ Has the patient had any orthodontic treatment before? _____

If yes, when and where? _____

Date of last dental examination _____

What would you most like to have orthodontic treatment accomplish? _____

Signature of parent/guardian _____ Date _____