PATIENT'S NAME: _____ PREFERRED NAME: _____ MARITAL STATUS: _____
(Last) (First) (S / M / D / W)

ADDRESS: _____ HOME #: _____
(Street Address) (City) (State) (Zip)

CELL #: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____ WORK #: _____
(Name of school if patient is a student)

DATE OF BIRTH: _____ SS #: _____ DENTIST: _____ PHONE#: _____

REFERRED BY: _____ FAMILY MEMBERS TREATED: _____

EMERGENCY CONTACT: _____ PHONE #: _____

PARENT/SPOUSE/GUARDIAN #1: _____ SS#: _____
(Last) (First)

ADDRESS: _____ HOME #: _____
(Street Address) (City) (State) (Zip)

CELL #: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____ WORK #: _____
(Name of school if patient is a student)

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

PARENT/SPOUSE/GUARDIAN #2: _____ SS#: _____
(Last) (First)

ADDRESS: _____ HOME #: _____
(Street Address) (City) (State) (Zip)

CELL #: _____ EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____ WORK #: _____
(Name of school if patient is a student)

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

ORTHODONTIC INSURANCE

PRIMARY			***SECONDARY***		
ORTHODONTIC COVERAGE:	❑ NO	❑ YES	ORTHODONTIC COVERAGE:	❑ NO	❑ YES
INSURANCE CO. NAME: _____			INSURANCE CO. NAME: _____		
INSURANCE CO. ADDRESS: _____			INSURANCE CO. ADDRESS: _____		
INSURANCE CO. PHONE #: _____			INSURANCE CO. PHONE #: _____		
GROUP # (PLAN OR POLICY #) _____			GROUP # (PLAN OR POLICY #) _____		
LIFETIME MAXIMUM BENEFIT: _____			LIFETIME MAXIMUM BENEFIT: _____		
INSURED'S NAME: _____			INSURED'S NAME: _____		
INSURED'S RELATION TO PATIENT: _____			INSURED'S RELATION TO PATIENT: _____		
INSURED'S DATE OF BIRTH: _____			INSURED'S DATE OF BIRTH: _____		
INSURED'S EMPLOYER: _____			INSURED'S EMPLOYER: _____		

MEDICAL HISTORY

HEALTH QUALITY: ❑ GOOD ❑ FAIR ❑ POOR ALLERGIES: 1. ❑ FOOD 2. ❑ DRUG 3. ❑ HAYFEVER 4. ❑ ASTHMA 5. ❑ LATEX 6. ❑ OTHER

PLEASE EXPLAIN: _____

HAS THE PATIENT HAD ANY OF THE FOLLOWING: (Please check)

1. ❑ HEPATITIS	8. ❑ EPILEPSY	15. ❑ DIZZINESS OR FAINTING	22. ❑ SPEECH IMPAIRMENT	29. ❑ HEMOPHELIA
2. ❑ FREQUENT HEADACHES	9. ❑ EXCESSIVE BLEEDING	16. ❑ SINUS PROBLEMS	23. ❑ TONSILS / ADENOIDS	30. ❑ DIFFICULT NOSE BREATHING
3. ❑ CEREBRAL PALSY	10. ❑ THYROID PROBLEMS	17. ❑ ARTHRITIS	24. ❑ MOUTH BREATHING	31. ❑ TMJ PROBLEMS
4. ❑ RHEUMATIC FEVER	11. ❑ KIDNEY PROBLEMS	18. ❑ CONVULSIONS / SEIZURES	25. ❑ THUMB / FINGER SUCKING	32. ❑ FACIAL PAIN
5. ❑ FREQUENT COLDS	12. ❑ BLEEDING GUMS	19. ❑ THROAT INFECTIONS	26. ❑ LIP OR TONGUE BITING	33. ❑ BONE PROBLEMS
6. ❑ DIABETES	13. ❑ LIVER DISEASE	20. ❑ GRINDING OF TEETH	27. ❑ NAIL BITING	34. ❑ OTHER
7. ❑ HEART DISEASE	14. ❑ COLD SORES / FEVER BLISTERS	21. ❑ IMMUNE DISORDER	28. ❑ TUBERCULOSIS	

PLEASE EXPLAIN: _____

PHYSICIAN: _____ UNDER PHYSICIAN'S CARE AT PRESENT: (Y or N)

FOR WHAT: _____

MEDICATIONS REGULARLY TAKEN & REASON: _____

DENTAL HISTORY

LAST DENTAL VISIT: _____ DENTAL WORK BEING DONE NOW? _____ IF YES, WHAT? _____

HAS THE PATIENT EVER RECEIVED A BLOW TO THE TEETH OR JAW? _____ IF YES, EXPLAIN: _____

HAS THE PATIENT HAD ORTHODONTIC TREATMENT OR EVALUATION? _____

IF YES, BY WHOM? _____ WHEN: _____

WHAT DO YOU FEEL ARE THE ORTHODONTIC PROBLEMS?

❑ ALIGNMENT OF TEETH ❑ DENTAL PROTRUSION ❑ FACIAL FEATURES ❑ OTHER

WHO FIRST NOTICED THE NEED FOR ORTHODONTIC TREATMENT? _____

ARE YOU INTERESTED IN (Please indicate all that apply):

❑ INFORMATION ❑ TREATMENT AT THIS TIME ❑ SECOND OPINION

CHANGES TO TEETH YOU WOULD LIKE TO SEE:

❑ UPPER TEETH ❑ LOWER TEETH ❑ LESS GUM SHOWING ❑ SPACING ❑ CROWDING

CHANGES TO FACIAL FEATURES YOU WOULD LIKE TO SEE:

❑ UPPER LIP ❑ LOWER LIP ❑ UPPER JAW ❑ LOWER JAW ❑ CHIN ❑ NOSE

WOULD YOU PREFER THAT FACIAL FEATURES NOT BE DISCUSSED IN FRONT OF THE PATIENT? ❑ DO NOT DISCUSS ❑ OK TO DISCUSS

IS THERE ANY SIGNIFICANT FAMILY HISTORY OF JAW OR TEETH PROBLEMS? ❑ YES ❑ NO

ARE YOU INTERESTED IN IMPROVING THE APPEARANCE OF THE TEETH AT THIS TIME - EVEN IF MORE TREATMENT WILL BE NEEDED LATER? ❑ YES ❑ NO

I certify that I have answered the above questions to the best of my ability. I will not hold Orthodontics Inc. or any member of it's staff, responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

Signature of Patient/Parent/Guardian: _____ Date _____