

**PATIENT INFORMATION**

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_  
 Last First Middle  
 Address \_\_\_\_\_  
 Street City State Zip  
 Home # \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
 If patient is a minor, give parent's or guardian's name \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 How did you hear about us? Check all that apply  A Friend \_\_\_\_\_  Internet Search \_\_\_\_\_  Our Website  
 Who? ie) Google  
 Social Media \_\_\_\_\_  Billboard \_\_\_\_\_  Radio \_\_\_\_\_  Magazine \_\_\_\_\_  
 Which One? Located Where? Station # Which One?  
 Newspaper \_\_\_\_\_  Yellow Pages \_\_\_\_\_  Other \_\_\_\_\_  
 Which One? Which One? Explain

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_ Marital Status \_\_\_\_\_  
 Last First Middle  
 Residence Address \_\_\_\_\_  
 Street City State Zip  
 Mailing Address \_\_\_\_\_  
 Street City State Zip  
 How long at this address? \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Cell # \_\_\_\_\_ Email address \_\_\_\_\_ (we notify you of next appt by text/email)  
 Previous address if less than 3 years \_\_\_\_\_  
 Street City State Zip  
 Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs. Employed \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Last First Middle  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Yrs. Employed \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work # \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Sec. # \_\_\_\_\_  
 Last First Middle  
 Insured's Address (if different from above) \_\_\_\_\_  
 Street City State Zip  
 Employer & Address \_\_\_\_\_  
 Insured's Birthdate \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Insurance Co. Name & Phone # \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Street City State Zip  
 Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_  
 Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:  
 Insured's Name \_\_\_\_\_ Insured's Social Sec. # \_\_\_\_\_  
 Last First Middle  
 Insured's Address (if different from above): \_\_\_\_\_  
 Street City State Zip  
 Insured's Birthdate \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_  
 Insurance Co. Name & Phone # \_\_\_\_\_  
 Insurance Co. Address \_\_\_\_\_  
 Street City State Zip  
 Insurance ID # \_\_\_\_\_ Group # \_\_\_\_\_ Local # \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION – not shared with anyone**

Name of nearest relative not living with you \_\_\_\_\_  
 Complete Address \_\_\_\_\_  
 Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Email address \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

**PERSONAL INFORMATION**

Nickname we may call the patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Dentist \_\_\_\_\_ Physician \_\_\_\_\_ School, if child \_\_\_\_\_ Grade \_\_\_\_\_  
Favorite Sports or Hobbies \_\_\_\_\_ Musical instruments played \_\_\_\_\_  
Does the patient have any personal problems or objections regarding wearing braces? \_\_\_\_\_  
Has any other member of the family had orthodontic treatment? If so, where? \_\_\_\_\_  
What is the main reason you need to see an orthodontist? \_\_\_\_\_

**MEDICAL HISTORY**

For the following questions please **circle** Yes, No, or don't know/understand (dk/u) to all answers that apply. Please **explain** all yes answers. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

Yes No dk/u	Birth defects or hereditary problems?	Yes No dk/u	Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects or rheumatic heart?
Yes No dk/u	Major Accidents?		Describe condition: _____
Yes No dk/u	Rheumatoid or Arthritic conditions?	Yes No dk/u	Allergies or Drug reactions? List: _____
Yes No dk/u	Endocrine or thyroid problems?		_____
Yes No dk/u	Diabetes	Yes No dk/u	Is the patient taking any type of prescription or non - prescription medication? If so, please list them.
Yes No dk/u	Kidney problems?		_____
Yes No dk/u	Cancer or tumor?	Yes No dk/u	Being treated by another health care professional? For: _____
Yes No dk/u	Stomach Ulcer?	Yes No dk/u	Has the patient ever been treated with antibiotics prior to a routine dental appointment? _____
Yes No dk/u	Aids or HIV positive?	Yes No dk/u	Is there any other medical or emotional condition you feel we should be made aware of that would prevent the patient from following instructions? _____
Yes No dk/u	Mental health, behavior or emotional problems, ADD or hyperactive condition?		_____
Yes No dk/u	High or low blood pressure?	Yes No dk/u	
Yes No dk/u	Females: Is it possible you could be pregnant? Due date? _____	Yes No dk/u	
Yes No dk/u	Has the patient ever taken any Bone Strengthening Medicines? _____		

**DENTAL HISTORY**

Yes No dk/u	Is the patient presently in any dental pain?	Yes No dk/u	Any history of injuries to the face, mouth, or teeth?
Yes No dk/u	Thumb or finger sucking habit? Until age _____	Yes No dk/u	Any relative with similar tooth or jaw relationship?
Yes No dk/u	Mouth breathing or snoring?	Yes No dk/u	Is the patient fearful of dental treatment?
Yes No dk/u	Pain or soreness in the muscles of the face?	Yes No dk/u	Has the patient ever had a "whiplash" injury?
Yes No dk/u	Jaw joint popping, clicking, or locking?	Yes No dk/u	History of Temporomandibular Joint Disorder, TMJ?
Yes No dk/u	Has any relative had jaw repositioning surgery?		
Yes No dk/u	Onset of puberty (approximate date)? _____	Yes No dk/u	Does patient need extra help with instructions?
Yes No dk/u	Has the patient ever had <u>prior</u> orthodontic treatment or examination? When and Where? _____		Date of most recent dental exam? _____

**BENEFITS**

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general dental health, and in the general function of the teeth. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. Successful treatment greatly depends on the patient completely following instructions, keeping appointments and maintaining good oral hygiene. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Jaw joint discomfort due to clenching and tooth root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth if retainers are not worn as prescribed. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Rice to perform a complete orthodontic evaluation.

Signature (Parent's Signature if minor) \_\_\_\_\_ Date \_\_\_\_\_

Treatment Coordinator \_\_\_\_\_