Date _____

Patients's Name _____ Spouse's Name_____

Home Address _____Phone _____

_____ Zip _____

Email Address _____

Occupation _____ S.S.# _____

Firm Name_____ Work Phone _____

Firm Address _____ Cell Phone _____

Medical Insurance? ❑ Yes ❑ No Name of Insurance Company _____

Dental Insurance Plan? ❑ Yes ❑ No Name of Insurance Company _____

Spouse's Occupation _____ S.S.# _____

Firm Name_____ Work Phone _____

Firm Address _____ Cell Phone _____

Medical Insurance? ❑ Yes ❑ No Name of Insurance Company _____

Dental Insurance Plan? ❑ Yes ❑ No Name of Insurance Company _____

How did you first learn about our office? _____

Who may we thank for referring you to our office? _____

Family Dentist _____

Family Physician _____

Your Birth Date Month / Day / Year Your Age _____

Your past general health? ❑ Good ❑ Other Explain _____

Any medical problems? _____

Are you allergic to any medications? _____

Are you now in good dental health? ❑ Yes ❑ No Dental check up every _____ months.

Check if you had or now have: ❑ Diabetes ❑ Blood Disorder ❑ Women, Pregnant? _____

❑ Allergic Reactions ❑ Liver Problems ❑ Rheumatic Fever/Heart Murmur _____

❑ Asthma/Breathing Problems ❑ Kidney Problems ❑ Infectious Disease _____

Cirle if you had or now have: periodontal problems (sore gums, bleeding gums) endodontic problems (root canals) clicking or popping in the jaw

Have you been examined by an orthodontist before? ❑ Yes ❑ No When _____

Where _____ Recommendations? _____

What, in your opinion, is the orthodonic problem? _____

I ACKNOWLEDGE THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY HEALTH STATUS. I ALSO UNDERSTAND THAT THE OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS PRIOR TO EXTENDING CREDIT FOR TREATMENT FEES, AND MAY AT THE DISCRETION OF THE OFFICE, USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES.

_____ _____

Signature of Patient (Parent/Gaurdian signature if patient is under age 18) Person Responsible for Treatment Fees