WELCOME TO OUR OFFICE

DATE_____
Updated _____
Updated _____

PATIENT'S NAME_____NICKNAME_____

D.O.B._____AGE_____ SEX M_____ F_____

ADDRESS_____TOWN_____STATE_____ZIP_____

HOME PHONE:_____Cell/Work PHONE_____EMAIL_____

PARENT/GUARDIAN FULL NAME_____

Home Address_____TOWN_____STATE_____ZIP_____

OCCUPATION _____EMPLOYED BY_____

HOME PHONE:_____ Cell/Work PHONE _____EMAIL_____

PARENT/GUARDIAN FULL NAME_____

Home Address_____TOWN_____STATE_____ZIP_____

OCCUPATION _____EMPLOYED BY_____

HOME PHONE:_____ Cell/Work PHONE _____EMAIL_____

PERSON RESPONSIBLE FOR THIS ACCOUNT_____

DO YOU HAVE AN *ORTHODONTIC* INSURANCE PLAN? YES___ NO_____

NAME OF INSURANCE COMPANY?_____GROUP #_____
(note: We ONLY accept DELTA DENTAL ins. but we will provide you with a "superbill" for you to send into your particular insurance company)

GENERAL APRAISAL Who can we thank for your referral?_____
CHIEF COMPLAINT (REASON FOR CONSULTATION)_____

HAVE YOU HAD PREVIOUS ORTHODONTIC TREATMENT? _____NO _____YES IF YES,

EXPLAIN_____

DOES PATIENT'S PROBLEM RESEMBLE _____FATHER _____MOTHER _____SIBLINGS

OTHER CHILDREN IN FAMILY	AGE	SEX	HAD ORTHO Treatment	NEEDS ORTHO Treatment
_____	____	____	_____	_____
_____	____	____	_____	_____

Please continue to page 2

Patient cont. _____

MEDICAL HISTORY

PHYSICIAN/PEDIATRICIAN _____ LAST EXAM _____

CURRENTLY UNDER MEDICAL TREATMENT ____NO YES__ explain _____
HISTORY OF RECENT ILLNESS ____NO YES__ explain_____
CURRENTLY TAKING MEDICATION ____NO YES__ explain _____
EVER BEEN HOSPITALIZED ____NO YES__ explain_____
EVER HAD AN OPERATION ____NO YES__ explain _____
ALLERGIC TO MEDICATIONS ____NO YES__ explain _____
ANY OTHER ALLERGIES ____NO YES__ explain _____
ONSET OF PUBERTY
BOYS - HAS HIS VOICE CHANGED? ___NO ___YES WHEN_____
GIRLS - HAS MENSTRUATION BEGUN? ___NO ___YES WHEN_____

DOES PATIENT HAVE A HISTORY OF:
____ANEMIA ____BONE DISORDERS _____EPILEPSY ____ASTHMA
____KIDNEY DISORDERS _____RHEUMATIC FEVER
____DIABETES ____LIVER INVOLVEMENT_____BLEEDING
PROBLEMS:
____HEART ____FAINTING OR DIZZINESS
_____ENDOCRINE DISORDERS

EXPLAIN _____

DENTAL HISTORY

DENTIST/PEDODONTIST_____ _____LAST EXAM_____

___ THUMB/FINGER SUCKING UNTIL AGE _____
___ MOUTHBREATHING _____AWAKE _____ASLEEP
___ GRINDING OR CLENCHING ____DAY ____NIGHT
___ NAIL-BITING
___ LIP BITING/LICKING
___ BLEEDING GUMS
___ INJURIES TO FACE/MOUTH/TEETH
___ SORENESS OR CLICKING IN JOINT ____NO ____YES

HOW FREQUENTLY DO YOU USE FLOSS _____

HAVE YOU BEEN INFORMED OF ANY EXTRA OR MISSING TEETH? _____

ANY FURTHER COMMENTS: