Patient Information

Patient's Name ______________________________ Age ______
Last First Middle

Address ______________________________ Male or Female
Street City State Zip

Home Phone (   ) ______________ Birthdate ____/____/____ Social Security # ______________
Month Day Year

Whom may we thank for referring you to our office? ______________________________

List other family members who are patients in this office ______________________________

Responsible Party Information

Name ______________________________
Last First Middle Martial Status

Residence ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

How long at this address ______________ Home Phone (   ) ______________ Work Phone (   ) ______________

Cell Phone (   ) ______________

Previous Address (if less than 3 yrs.) ______________________________
Street City State Zip

Social Security # ______________ Birthdate ____/____/____ Relationship to Patient ______________
Month Day Year

Employer ______________ Occupation ______________ No. Years Employed ______

Spouse's Name ______________________________ Relationship to Patient ______________
Last First Middle

Employer ______________ Occupation ______________ No. Years Employed ______

Social Security # ______________ Birthdate ____/____/____ Work Phone (   ) ______________
Month Day Year

Cell Phone (   ) ______________

Health History

Family Dentist Name: ______________________________ City: ______________

List any significant medical history or disease: ______________________________

Any medication being taken? ______________ Physician: ______________

List any injuries to face or mouth ______________________________ What age? ______

Has patient been examined by an orthodontist before? ______________ When? ______________

Who? ______________ Where? ______________

Reason for seeking orthodontic care? ______________________________

Please underline and list any oral habits patient may have: Lip, Cheek or Tongue Biting; Finger, Thumb or Lip Sucking?

____

Can you associate your orthodontic condition with any habits? ______________ Heredity? ______________

What do you wish to gain through orthodontic treatment? ______________________________

Emergency Information

Please give emergency name and phone number, other than yourself, we may call if contact needs to be made for patient:

Name: ______________________________ Telephone (   ) ______________

Date: ____/____/____ Signature: ______________________________
Month Day Year

(Parent or Guardian if patient under 18)