Specialist In Orthodontics and Dentofacial Orthopedics

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A B C

PATIENT INFORMATION

LAST NAME	FIRST NAME	NICKNAME	SSN	SEX	BIRTH DATE	AGE

MAILING ADDRESS	CITY	STATE	ZIP	HOME#

SCHOOL (IF STUDENT)	GRADE	[ ] SINGLE [ ] MARRIED	[ ] DIVORCED [ ] WIDOW	EMPLOYER/OCCUPATION	YEARS EMPLOYED	WORK #

EMAIL	FAX #	CELL #

WHO MAY WE THANK FOR RECOMMENDING US?	NAME OF DENTIST	DATE OF LAST CLEANING

RELATED PATIENTS THAT ARE OR HAVE BEEN UNDER OUR CARE		NAMES AND AGES OF OTHER CHILDREN	
1.	3.	1.	3.
2.	4.	2.	4.

EMERGENCY CONTACT INFORMATION: NAME	PHONE NUMBER
ADDRESS	

PARENT INFORMATION - PLEASE COMPLETE IF PATIENT IS A MINOR

FATHER'S NAME	SSN	D.O.B.

ADDRESS	HOW LONG AT THIS ADDRESS

CITY	STATE	ZIP

PREVIOUS ADDRESS IF LESS THAN THREE YEARS

EMAIL

HOME #	CELL #

EMPLOYER / OCCUPATION	YEARS EMPLOYED	WORK #

INSURANCE COMPANY	ID #	GROUP NUMBER

MOTHER'S NAME	SSN	D.O.B.

ADDRESS	HOW LONG AT THIS ADDRESS

CITY	STATE	ZIP

PREVIOUS ADDRESS IF LESS THAN THREE YEARS

EMAIL

HOME #	CELL #

EMPLOYER / OCCUPATION	YEARS EMPLOYED	WORK #

INSURANCE COMPANY	ID #	GROUP NUMBER

OTHER

NAME	RELATION TO PATIENT	EMPLOYER / OCCUPATION

CITY	STATE	ZIP	HOME #	

WORK #	CELL #	FAX #	EMAIL

INSURANCE COMPANY	ID #	MAY PATIENT INFORMATION BE RELEASED TO THE NON-CUSTODIAL PARENT? [YES] [NO]

I hereby authorize payment directly to Braces For All Ages, PC (dentist) of the Group Insurance Benefits otherwise payable to me.

Signed (Insured Person) ______________________________ Date ______________

Signed (Insured Person) ______________________________ Date ______________

MEDICAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

- [ ] Joint Swelling
- [ ] Bone Disorders
- [ ] Heart Trouble
- [ ] Mitral Valve Prolapse
- [ ] Rheumatic Trouble
- [ ] Diabetes
- [ ] Emotional Problems
- [ ] Brain Injury
- [ ] Kidney or Liver Involvement
- [ ] Joint Prosthesis
- [ ] Tuberculosis
- [ ] Anemia
- [ ] Epilepsy (Convulsions)
- [ ] Prolonged Bleeding
- [ ] Faintness/Dizziness
- [ ] Tonsils Removed
- [ ] Adenoids Removed
- [ ] Sore Throat
- [ ] Tonsilitis
- [ ] Earaches
- [ ] Arthritis
- [ ] Latex Allergy
- [ ] Thyroid Problems
- [ ] Metal Allergy

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:

[Y] [N] Rheumatoid Arthritis?
[Y] [N] Lupus?

ARE YOU PREGNANT?

[Y] [N]

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION

____

____

____

____

Is patient presently under physician care for any reason?

____

____

Name of primary physician ______________________________

____

Other ______________________________

List any other serious illnesses ______________________________

____

Adolescent Females: Has menstruation begun?

Date: Month/Year ______________________________

Approximately how much has the patient grown the last year?

____

DENTAL HISTORY

PLEASE CHECK IF PATIENT HAS OR HAS HAD THE FOLLOWING:

- [ ] Any injuries to face, mouth or teeth
- [ ] Thumb, finger or lip sucking
- [ ] More than average amount of tooth decay
- [ ] Extra permanent teeth
- [ ] Teeth removed by extraction
- [ ] Difficulty in swallowing or chewing
- [ ] History of gum problems
- [ ] Previous orthodontic treatment

When ______________________________

Where ______________________________

Does patient require pre-medication? [Y] [N]

Is patient a mouth breather? [Y] [N]

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION

____

____

____

____

____

List drugs or medications now being taken

____

____

____

Do you take any medications for osteoporosis? [Y] [N]

If yes, please list: ______________________________

List any allergies ______________________________

____

What do you want to accomplish with orthodontic treatment?

____

____

Patient's attitude toward orthodontic treatment:

[ ] Very Motivated [ ] Will Cooperate If Needed [ ] Not Motivated

We are sorry that we cannot accept divorce decrees as assignments or responsibility for a child's orthodontic bills. To the best of my knowledge, the above information is complete and correct. I give my permission for any photographs, x-rays, or study models to be used for displays at scientific meetings presentations, and publications of a scientific nature or for study group purposes to further the art and science of orthodontics. I understand where appropriate, credit bureau reports may be obtained.

Signature ______________________________ Date ______________