Minor Patient Information

(Adult Patient Use Box Below)

Date: ____________________

Patient's Name ____
Last First Middle

Address ____

Home Phone ______________ 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? ______________________

Responsible Party Information / Adult Patient

Name ______________________________ Marital Status ______________
Last First Middle

Residence ____

Mailing Address ____

How Long at this address _______ ❑ Rent ❑ Own

Previous Address (if less than 3 years) ______________________________

Phone: Home ____________ Work ____________ Cell ____________ Email ____________

Social Security # ____________ Birthdate ____________ Relationship to Patient ____________

Employer ____________ Occupation ____________ Number years employed ________

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

Employer ____________ Occupation ____________ Number years employed ________

Social Security # ____________ Birthdate ____________ Work Phone ____________

Insurance Information

Insured's Name ______________________________ Insured's ID # ____________
Last First Middle

Insurance Company ______________________ Group No. ____________

Insured's Employer ____

I authorize payment to Braces For All Ages, PC ______________________

Do you have dual coverage? ❑ Yes ❑ No If yes: Insurance Co. Phone # ____________

Insured's Name ______________________________ Insured's ID # ____________

Insurance Company ______________________ Group No. ____________

I authorize payment to Braces For All Ages, PC ______________________

Insured's Employer ____

Emergency Information

Name of nearest relative not living with you ______________________________

Complete Address ____

Phone (______) ______________________ Relationship ______________________

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
[ ] Metal Allergy
[ ] Thyroid Problems
[ ] Peanut Allergy

HAVE YOU OR ANY MEMBERS OF YOUR FAMILY HAD:

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

[Y] [N] Do you have a latex allergy?

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

General Dentist ______________________________

Last Cleaning ______________________________

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 ______________________________

Dental treatment recommended by DDS that is not done.
When is it scheduled? ______________________________

[ ] **Grinding** [ ] **TMJ** [ ] **Clenching**

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

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

ON ITEMS CHECKED, PLEASE PROVIDE A MORE DETAILED DESCRIPTION

____
____
____
____
____

Does patient make any noises while sleeping? [Y] [N]
More than normal ear infections or stuffy nose? [Y] [N]
Does either parent have sleep apnea? [Y] [N]

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

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

Signature (Parent's signature if minor) ______________________________

Updates (date and Initial) ______________________________