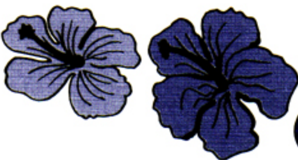

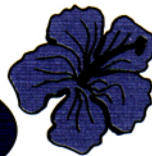

Personal Information

PATIENT'S NAME ______________________ AGE ________

ADDRESS ______________________ CITY ____________ ZIP ________

HOME PHONE ____________ CELL ____________ BIRTH DATE ________

SOCIAL SECURITY # ______________________

EMPLOYED BY ______________________ OCCUPATION ____________

BUSINESS ADDRESS ______________________ BUS PHONE ____________

HOBBIES & INTERESTS ______________________

SPOUSE'S NAME ______________________ BIRTH DATE ________ SS # ________

EMPLOYED BY ______________________ OCCUPATION ____________

BUSINESS ADDRESS ______________________ BUS PHONE ________ CELL ________

INSURANCE INFORMATION:

PERSON(S) FINANCIALLY RESPONSIBLE ______________ PHONE ____________

DO YOU HAVE DENTAL INSURANCE? ______________ NAME OF COMPANY ____________

INSURED SOCIAL SECURITY # ______________ **INSURED BIRTHDATE** ____________

WHO MAY WE THANK FOR REFERRING YOU? ______________________

MEDICAL HISTORY:

DENTIST ____________ PHYSICIAN ____________ ORAL SURGEON ____________

	YES	NO		YES	NO		YES	NO
DIABETES	☐	☐	***ANEMIA***	☐	☐	***PROLONGED BLEEDING***	☐	☐
PNEUMONIA	☐	☐	***EPILEPSY***	☐	☐	***FAINTING / DIZZINESS***	☐	☐
HEART TROUBLE	☐	☐	***ASTHMA***	☐	☐	***NERVOUS DISORDERS***	☐	☐
RHEUMATIC FEVER	☐	☐	***KIDNEY INVOLVEMENT***	☐	☐	***LIVER INVOLVEMENT***	☐	☐
BONE DISORDERS	☐	☐	***TUBERCULOSIS***	☐	☐	***ENDOCRINE PROBLEMS***	☐	☐
HEPATITIS	☐	☐	***GLAUCOMA***	☐	☐	***HIV / AIDS***	☐	☐

LIST ANY DRUGS OR MEDICATIONS NOW BEING TAKEN: ______________________

HAVE YOU EVER TAKEN PHEN-PHEN? YES ☐ NO ☐

HISTORY OF ALLERGIES OR DRUG SENSITIVITY: (SPECIFY) ______________________

(FEMALES) PREGNANCY YES ☐ NO ☐ ARE YOU PRESENTLY TAKING BIRTH CONTROL PILLS? YES ☐ NO ☐

DENTAL HISTORY:

HAVE THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH? ______________ YES ☐ NO ☐

ARE YOU AWARE OF HAVING A MOUTH BREATHING HABIT? ______________ YES ☐ NO ☐

HAVE YOU BEEN INFORMED OF ANY MISSING OR EXTRA PERMANENT TEETH? ______________ YES ☐ NO ☐

HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? ______________ YES ☐ NO ☐

HAS PATIENT HAD PREVIOUS ORTHODONTIC TREATMENT? ______________ YES ☐ NO ☐

DATE OF LAST DENTAL EXAMINATION? ______________________

WHAT WOULD YOU MOST LIKE TO HAVE ORTHODONTIC TREATMENT ACCOMPLISH? ______________________

____

SIGNATURE ______________________ DATE ____________

CHARGES THAT MAY BE INCURRED EXCLUSIVE OF TREATMENT FEE: INITIAL EXAM, INITIAL STUDY MODELS, DIAGNOSTIC CONSULTATION
(If treatment is initiated in our office the consultation and diagnostic fee is exclusive)

A Service charge of 1.5% per month will be applied to all delinquent balances over 90 days.