Date_____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

How long at this address_____ Previous Address_____
(if less than 3 yrs) Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____ Relationship to Patient_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

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?_____

Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

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

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

Personal Information

Nickname we may call the patient: _____ Age: ____ Sex: ____ Height: ____ Weight: _____

Dentist: _____ Physician: _____ School, if Child: _____ Grade: ____

Favorite Sports or Hobbies: _____ Musical Instruments played: _____

Does the patient have any personal problems or objections regarding wearing braces? _____

Has any other member of the family had orthodontic treatment? If so where? _____

What is the primary concern for visiting our office? _____

Medical History

For the following questions please circle Yes, No, or don't know/understand (dk/u). The answers are for office records only and will be considered confidential A thorough and complete history is vital to a proper orthodontic evaluation. Please explain all yes answers and circle all answers that apply.

Yes No dk/u Birth defects or hereditary problems?

Yes No dk/u Major accidents?

Yes No dk/u Rheumatoid or arthritic conditions?

Yes No dk/u Endocrine or thyroid problems?

Yes No dk/u Diabetes?

Yes No dk/u Kidney problems?

Yes No dk/u Cancer or tumor?

Yes No dk/u Stomach Ulcer?

Yes No dk/u Aids or HIV positive?

Yes No dk/u Mental health, behavior or emotional problems, ADD or hyperactive condition?

Yes No dk/u High or low blood pressure?

Yes No dk/u Are you being treated for osteoporosis?

Yes No dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke inborn heart defects or rheumatic heart?

Describe condition: _____

Yes No dk/u Allergies or Drug reactions?
List: _____

Yes No dk/u Is the patient taking any type of prescription or non-prescription medication? If so, please list them. _____

Yes No dk/u Being treated by another health care professional?
For: _____

Yes No dk/u Has the patient ever been treated with antibiotics prior to a routine dental appointment?
If yes please describe: _____

_____

Dental History

Yes No dk/u Thumb or finger sucking habit? Until age____

Yes No dk/u Mouth breathing or snoring?

Yes No dk/u Pain or soreness in the muscles of the face?

Yes No dk/u Jaw joint popping, clicking, or locking?

Yes No dk/u Has any relative had jaw repositioning surgery?

Yes No dk/u Onset of puberty (approximate date)? _____

Yes No dk/u Any relative with similar tooth or jaw relationship?

Yes No dk/u Is the patient fearful of dental treatment?

Yes No dk/u Has the patient ever had a "whiplash" injury?

Yes No dk/u History of Tempromandibular Joint Disorder, TMJ?

Yes No dk/u Has the patient ever had prior orthodontic treatment or an examination?

Yes No dk/u Date of most recent dental examination _____

Realizing that successful treatment greatly depends upon the patients complete cooperation in following instructions, keeping appointments and maintaining oral hygiene, are there any restrictions, handicaps, or problems that might be encountered during treatment?

_____

_____

_____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status I will so inform this practice.

Signature (Parent's signature if minor):_____

Treatment Coordinator:_____