DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

DR. SUZANNE STOCK
ORTHODONTIST
Orthodontics for Children & Adults

Member American Association of Orthodontists

PATIENT INFORMATION

Patient's Name ______________________________ Age ________ Birthdate ________________
First Middle Last

Preferred Name ______________________ ☐ Male ☐ Female Patient's Home Phone ________________

Patient's Home Address ______________________ City, State, ZIP ________________

Patient (not parent) Email (if applicable, for appt reminders and contests) ________________

General Dentist: ______________________ Last Visit Date: ___/___/___ Physician: ________________

If Student, School/College ______________________________

If Adult, Employer ______________________________ Work Phone ________________

How did you hear about our office? ☐ Patient's Dentist ☐ Other ________________

PARENT INFORMATION (if patient is a minor)

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Father/Mother ☐ Step Father/Mother ☐ Guardian ☐

Name ______________________
Address ______________________
Birthdate ______________________
Home Phone ______________________
Cell Phone ______________________
Employer ______________________
Work Phone ______________________
Email ______________________

Mother/Father ☐ Step Mother/Father ☐ Guardian ☐

Name ______________________
Address ______________________
Birthdate ______________________
Home Phone ______________________
Cell Phone ______________________
Employer ______________________
Work Phone ______________________
Email ______________________

Email addresses will only be used for appointment reminders and other important notices. With your email, you can also login online to the patient's account.

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Employer ______________________ Occupation ________________

Insurance Company Name ______________________ Insurance Company Phone ________________

Insurance Company Address ______________________________

Insured's Name ______________________ Insured's Birthdate ________________

Relationship ____________ Insured's ID # ______________________ Group or Plan # ____________

SECONDARY DENTAL INSURANCE INFORMATION

Insured's Employer ______________________ Occupation ________________

Insurance Company Name ______________________ Insurance Company Phone ________________

Insurance Company Address ______________________________

Insured's Name ______________________ Insured's Birthdate ________________

Relationship ____________ Insured's ID # ______________________ Group or Plan # ____________

Please fill out reverse side.

Patient's Name ______________________________ Birthdate ____________________

DENTAL AND MEDICAL HISTORY

History of major illness? ☐ YES ☐ NO If YES, please describe ______________________________

Any sensitivities or allergies? ☐ YES ☐ NO If YES, please list ______________________________

Currently taking any medications? ☐ YES ☐ NO If YES, please list ______________________________

Has the patient been treated for any of the following?

☐ Arthritis	☐ Blood Disorder	☐ Diabetes	☐ Heart Condition	☐ Tuberculosis
☐ Asthma	☐ Osteoporosis	☐ Epilepsy	☐ Nervous Disorder	☐ Tonsils/Adenoids

Has your physician/dentist recommended the patient take antibiotics before dental treatment? ☐ YES ☐ NO

If YES, medication: ______________________________

Have you been informed of any missing or extra teeth? ☐ YES ☐ NO

Have there been injuries to the patient's face, mouth or chin? ☐ YES ☐ NO If YES, explain: ______________________________

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Has the patient ever had pain/tenderness in the jaw joint (TMJ/TMD)? ☐ YES ☐ NO If YES, explain: ______________________________

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Does/Did the patient have any of the following habits?

☐ Grinding Teeth	☐ Finger/Thumb Sucking	☐ Tongue Thrusting
☐ Mouth Breather	☐ Speech Problems	☐ Chewing/Eating Problems

Are there other dental issues not listed that you would like to discuss or have treated? ☐ NO ☐ YES If YES, please explain:

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SIGNATURE

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I have read the notice of privacy practices available at the front desk. I hereby authorize release of any information related to insurance claim. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature ______________________________ Date ______________________________

OFFICE USE ONLY

Molar Relation	Right	Left	Overbite	Overjet	Tooth Size
Cuspid Relation	Right	Left	X-Bite	Open Bite	Crowding
Midline	Upper	Lower	Hygiene	Periodontal Condition	Caries
Decalcification		Lip Tone	Frenum	Tongue Thrust	TMJ