DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

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ORTHODONTIST
Orthodontics for Children & Adults

Member American Association of Orthodontists

PATIENT INFORMATION

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

Preferred Name ____________________ Gender__________ 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. If you would like to receive appointment reminders via text message, please list your cell phone number here ______________________.

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

Has the patient been treated for any of the following?

☐ Arthritis ☐ Blood Disorder ☐ Diabetes ☐ Heart Condition ☐ Tuberculosis

☐ Asthma ☐ Osteoporosis ☐ Epilepsy ☐ Nervous Disorder ☐ Tonsils/Adenoids

Please list all other physical and mental health conditions: ______________________

Please list all medications: ______________________

Is the patient allergic to latex? ☐ YES ☐ NO

Please list all other allergies: ______________________

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: ______________________

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

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

☐ Grinding Teeth ☐ Finger/Thumb Sucking ☐ Tongue Thrusting

☐ Mouth Breather ☐ Speech Problems ☐ Chewing/Eating Problems

What would you like fixed with orthodontic treatment? ______________________

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