

# Welcome To Our Office

**Patient information:**

**Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Patients Address: \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Cell #: \_\_\_\_\_  
School/Employer: \_\_\_\_\_ Grade/Position: \_\_\_\_\_  
Interest/Sports \_\_\_\_\_

## Primary

€ Mother € Father € Step Parent € Self € Other (specify) \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

## Secondary

€ Mother € Father € Step Parent € Self € Other (specify) \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Address: \_\_\_\_\_ How Long? \_\_\_\_\_  
Employer/Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

How Did You Hear About Us? € Dentist € Patient € Relative € Friend € Internet € Ad € Other \_\_\_\_\_  
Whom May We Thank For Referring You To Us? \_\_\_\_\_ Present Dentist: \_\_\_\_\_

**Circle Yes or No for which the patient has a history:**

Allergies	Y N	Diabetes	Y N	Fainting/ Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	TMJ problems	Y N
Arthritis	Y N	Downs Syndrome	Y N	Headaches	Y N	Nervous Disorders	Y N	Seizures	Y N	Tooth Grinding	Y N
Asthma	Y N	Drug allergies	Y N	Heart condition	Y N	Painful chewing	Y N	Sinus Problems	Y N	Tuberculosis	Y N
Bleeding Gums	Y N	Emotional disorders	Y N	Hepatitis	Y N	Periodontal problems	Y N	Snoring	Y N		
Clicking of jaw	Y N	Epilepsy	Y N	Liver/Kidney	Y N	Pregnant	Y N	Speech problems	Y N		

Any allergies to Latex? \_\_\_\_\_

Any disease, problems, or allergies not mentioned above? \_\_\_\_\_

Current Medications? \_\_\_\_\_

Have wisdom teeth been extracted? \_\_\_\_\_ Any face, mouth or teeth injuries? \_\_\_\_\_

Does the patient normally breathe through the mouth while awake or asleep? \_\_\_\_\_ Do gums bleed when brushed or flossed? \_\_\_\_\_

Has an orthodontist been consulted previously? \_\_\_\_\_ Have you had previous orthodontic treatment? \_\_\_\_\_

Are there any missing or extra teeth? \_\_\_\_\_ Have the Tonsils and adenoids been removed? \_\_\_\_\_

Any other questions? \_\_\_\_\_

Do you have any Siblings/Children in treatment with us? \_\_\_\_\_

## Insurance Information (Please fill out completely so we may properly file your insurance)

Name of Primary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_  
€ Mother € Father € Step Parent € Self € Other (specify) \_\_\_\_\_

Policy Holders Birthdate: \_\_\_\_\_ Would you like our office to file claim and receive benefits from your insurance company? ? € Yes € No  
Initials \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Name of Secondary Orthodontic Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_  
€ Mother € Father € Step Parent € Self € Other (specify) \_\_\_\_\_

Policy Holders Birthdate: \_\_\_\_\_

Would you like our office to file claim and receive benefits directly from your insurance company? € Yes € No  
Initials \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_ Date: \_\_\_\_\_

