

Welcome! Thank you for choosing our office for your orthodontic needs. Our goal is to make your experience as productive and pleasant as possible. We promote preventive care and encourage proper oral hygiene to help you achieve and maintain optimal aesthetics, function, stability and oral health. We are committed to exceeding your expectations. Congratulations, you've taken the first step to obtain a natural, healthy and beautiful smile to last a lifetime!

PATIENT INFORMATION		Date	Pt #	Model #
Patient Name _____	Nickname _____	Sex: M F	Birthdate _____	Age _____
Address _____	City _____	State _____	Zip _____	
Social Security # _____	Home Phone _____	Cell Phone _____	Email _____	
School or Employer _____	Grade or Occupation _____			
Do You Expect to Move or Transfer in the Near Future? Y N		If Yes, When? _____		
How Did You Hear About Us? _____		Other Family Members or Friends Seen by Us _____		
Siblings or Children: Yes No		Name/Age _____	Name/Age _____	Name/Age _____

RESPONSIBLE PARTY INFORMATION				
Responsible Party _____	Relationship to Patient _____	Marital Status: S M W D		
Home Address _____	City _____	State _____	Zip _____	
Own or Rent? _____	How Long At This Address? _____	Mailing Address (if different) _____		
Social Security # _____	Birthdate _____	Phone _____	Email _____	
Driver's License # _____	Employer _____	Occupation _____	# of Years Employed _____	
Employer Address _____	Work Phone _____			
Spouse's Name _____	Social Security # _____	Birthdate _____		
Driver's License # _____	Employer _____	Occupation _____	# of Years Employed _____	
Employer Address _____	Work Phone _____			
(If Separate Accounts Requested, Please Indicate Additional Responsible Party)				
2nd Responsible Party _____	Relationship to Patient _____	Marital Status: S M W D		
Home Address _____	City _____	State _____	Zip _____	
Own or Rent? _____	How Long At This Address? _____	Mailing address (if different) _____		
Social Security # _____	Birthdate _____	Phone _____	Email _____	
Driver's License # _____	Employer _____	Occupation _____	# of Years Employed _____	
Employer Address _____	Work Phone _____			

ORTHODONTIC INSURANCE INFORMATION			
Primary Insured's Name _____	Insured's Birthdate _____	Insured's SSN _____	
Insured's Employer _____	Employer Address and Phone _____		
Insurance Company and Phone _____	Group # _____		
Insurance Company Address _____	Fax or Website _____		

EMERGENCY CONTACT INFORMATION		
Name of Nearest Relative or Friend Not Living with Patient _____	Home Phone _____	
Address _____	Work Phone _____	Cell Phone _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____ Current Medical Status: Good Fair Poor

Please Circle YES or NO. (If YES, please specify.)

YES NO Are you taking any prescription or over-the-counter medications? _____

YES NO Do you have any allergies (e.g. metal, latex, drug, plastic, or food)? _____

YES NO Do you have history of major illness, hospitalization or serious accident? _____

Please circle any of the following medical conditions that YOU have had or currently have:

AIDS	Diabetes	Handicaps/Disabilities	Kidney Disorders	Rheumatic Fever
Arthritis	Dizziness/Fainting	Heart Problems	Liver Disorders	Sensory Difficulties
Asthma	Drug/Alcohol Abuse	Hepatitis	Musculoskeletal Disorders	Speech Problems
Birth Defect	Endocrine Disorders	Herpes	Pneumonia	Tobacco Habit
Blood Disorders	Epilepsy	High or Low Blood Pressure	Psychological/Psychiatric Conditions	Tuberculosis
Bone Disorders	Gastrointestinal Disorders	Immunological Disorders	Respiratory Disorders	Tumor or Cancer

Are there any other medical / clinical / family conditions or history that we should be aware of? _____

If CHILD, have you reached puberty (girls: menstruation started; boys: voice changed)? YES NO If so, approximately when? _____

DENTAL HISTORY

Dentist _____ Date of Last Cleaning _____ Current Dental Status: Good Fair Poor

WHAT CONCERNS YOU MOST ABOUT YOUR TEETH, BITE or SMILE? Why Are You Here Today? _____

YES NO Are you presently in dental pain / discomfort or have tooth sensitivity to pressure, hot, cold or sweet?

YES NO Any history of significant trauma to the face, jaw or chin? Chipped or injured teeth? Jaw joint (TMJ) pain or discomfort?

YES NO Do your gums bleed? Have you ever been treated for gum problems, attachment loss, bone loss or periodontal disease?

YES NO Have you been informed of any congenitally missing or supernumerary (extra) teeth?

Do you have (had) any of the following habits? (Please check all that apply)

<input type="checkbox"/> Chewing Snuff / Tobacco	<input type="checkbox"/> Lip Sucking / Biting	<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Thumb or Finger Sucking
<input type="checkbox"/> Clenching / Grinding	<input type="checkbox"/> Mouth Breathing	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Tongue Thrust or Lisp

YES NO Have You Been Evaluated For Braces (or Had Braces) Before? _____

What you consider to be the main benefit(s) of orthodontic correction?

Cosmetic Functional Psychological / Emotional Other _____

Patient's attitude(s) toward orthodontic treatment?

Enthusiastic Indifferent Apprehensive Other _____

SIGNATURE

I certify that the information I have given is complete and correct to the best of my knowledge and that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of changes in medical/dental status. I authorize the orthodontic staff to perform any necessary services for diagnosis and treatment. I give permission for any photographs, X-rays and study models to be used at scientific meetings, presentations and publications of a scientific nature or study group to further the art, science and education of orthodontics. I understand that late payments over 30 days are subject to a finance fee. If applicable, I authorize insurance payment of orthodontic benefits directly to this office as well as authorize release of all information necessary to secure payment. I agree to pay any fees not paid by insurance and all collection fees, should my account become delinquent. I authorize this office to verify my credit history prior to extending credit to me, and that this office may use the services of one or more credit reporting agencies. In case of divorce, I accept that the accompanying parent will pay for services and seek reimbursement from other parent. Finally, I understand that the Notice of Privacy Practice is accessible in the reception area for my review and a copy is provided upon request.

Signature of Patient / Parent or Legal Guardian _____ **Date** _____