Patient Name: _____ Email Address for Confirmation: _____

Patients Address: _____ City _____ Zip _____ Home #: _____

Birthdate: _____ Age: _____ Sex: _____ Cell #: _____

School: _____ _____

Interests/Hobby _____

Employer

Name: _____ How Long?: _____

Address: _____ Telephone: _____

Zipcode: _____ ___

Social Security Number: _____ Birthdate: _____

Spouse

Name: _____ Phone: _____

Address/Zipcode _____ ___

Employer Name & Address/Zipcode _____ How Long? _____

Social Security Number: _____ Birthdate: _____

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other _____

Whom May We Thank For Referring You To Us? _____ Present Dentist: _____

Reason For Consultation: _____

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

Aids	Y N	Cancer	Y N	Endocrine problems	Y N	Immune problems	Y N	Pneumonia	Y N	TMJ problems	Y N
Allergies	Y N	Cerebral palsy	Y N	Emotional disorders	Y N	Kidney problems	Y N	Pregnant	Y N	Tooth Grinding	Y N
Anemia	Y N	Chest pains	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Prolonged Bleeding	Y N	Neck pain	Y N
Arthritis	Y N	Finger Habit	Y N	Fainting, Dizziness	Y N	Mouth breathing	Y N	Rheumatic Fever	Y N	Clicking of jaw	Y N
Aspirin	Y N	Thumb Habit	Y N	Glaucoma	Y N	Muscular disorders	Y N	Scoliosis	Y N	Headaches	Y N
Asthma	Y N	Cold Sores/Herpes	Y N	Gags Easily	Y N	Nervous Disorders	Y N	Seizures	Y N	Popping in jaw	Y N
Autoimmune	Y N	Diabetes	Y N	Heart condition	Y N	Organ Transplant	Y N	Sicca	Y N	Diet Pills Taken	Y N
Bone Disorders	Y N	Downs Syndrome	Y N	Mitral Valve Prolapse	Y N	Painful chewing	Y N	Speech problems	Y N	Venereal Disease	Y N
Bulimia	Y N	Drug allergies	Y N	High Blood Pressure	Y N	Periodontal problems	Y N	Tuberculosis	Y N	Hepatitis	Y N

Any disease, problems, or allergies not mentioned above? _____

Current Medications? _____

Females: Have you started Menstruating? _____ At what age? _____

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? _____

Have you or are you taking any bone density medications? _____ Have Tonsils and Adenoids been removed? _____ _____

Specific TMJ Problem? (Please Circle Those That Apply) Popping Clenching Muscle Soreness Restricted Opening _____

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: _____ $Maximum_____ % Payable_____ Age___ Time____

Name of Secondary Orthodontic Insurance: _____ Telephone: _____

Name of Policy Holder: _____ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) _____

Policy Holders Birthdate: _____ $Maximum_____ % Payable_____ Age_____ Time_____

Signature: _____ Date: _____ _____