We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

Patient Information

Patient's Name ______________________________ Age ______ Birth Date ____________
First Middle Last

Nickname (if preferred) ______________________ Male Female

Home Phone ______________________ Cell Phone ______________________ SS # ______________________

Home Address ______________________________ City, State, ZIP ______________________
Street

Employer ______________________ Employer's Address ______________________

Occupation ______________________ How Long? ____________

General Dentist ______________________ How did you hear about our office? ______________________

Have we treated another member of your family? YES NO If YES, Name ______________________
First Middle Last

What are the main concerns that you would like orthodontics to accomplish? ______________________

Have you visited an orthodontist before? YES NO If YES, for what reason? ______________________

Anything you would like to discuss with the doctor in private? YES NO

Insurance Information

Marital Status Single Married Widowed Divorced Separated Domestic Partner

Primary

Insurance Company Name ______________________ Insurance Company Phone ______________________

Insurance Company Address ______________________ Group or Plan ______________________

Insured's Name ______________________ Insured's Birthdate ______________________

Relationship ______________________ Insured's SS # ______________________

Insured's Employer ______________________ Employer's Address ______________________

Secondary

Insurance Company Name ______________________ Insurance Company Phone ______________________

Insurance Company Address ______________________ Group or Plan ______________________

Insured's Name ______________________ Insured's Birthdate ______________________

Relationship ______________________ Insured's SS # ______________________

Insured's Employer ______________________ Employer's Address ______________________

Dental and Medical History

Are you currently under the care of a physician? YES NO If YES, for what reason? ____________________

Physician ______________________________ Phone # ______________

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 ______________ Amount/Dose ________

Have you been treated for any of the following?

Arthritis	Blood Disorder	Diabetes	Heart Condition	Tuberculosis
Asthma	Cancer	Epilepsy	Nervous Disorder	High Blood Pressure

Do you require antibiotics before dental treatment? YES NO If YES, explain ______________________

Have there been injuries to your face, mouth or chin? YES NO

Have you ever had pain/tenderness in your jaw joint (TMJ/TMD) YES NO

Do/Did you have any of the following habits?

Grinding Teeth	Finger/Thumb Sucking	Tongue Thrusting
Chronic Mouth Breathing	Speech Problems	Chewing/Eating Problems

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 medical information.

I hereby authorize release of any information related to insurance claim. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature ______________________________ Date ____________________