**Confidential Patient and Family Information**

We keep our families grouped together to assure more convenient appointment scheduling and application of family discounts. Please take a few minutes to complete all sections below. It’s OK to skip the pink section if you have already completed it for another family member.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient’ Name: |  | Gender: M [ ]  F [ ]   | Date of Birth: |  |
|  First Middle Initial Last mm dd yyyy  |
| Nickname:  |  | Hobbies/Sports |  |
| Address: |  | Home Phone: |  |
|  Street City State Zip xxx xxx-xxxx  |
| Cell Phone: |  | Cell Phone: |  |
|  Whose phone: Patient? [ ]  Mom? [ ]  Dad? [ ]  Spouse? [ ]  Other? [ ]  Whose phone: Patient? [ ]  Mom? [ ]  Dad? [ ]  Spouse? [ ]  Other? [ ]   |
| Email Address: |  | Email Address: |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Family member |  | Relationship |  | Age |  | Family member |  | Relationship |  | Age |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
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|  |  |
| --- | --- |
| Who can we thank for inviting you to join our practice? |  |

**Confidential Account and Insurance Information**

This information allows us to tailor payment plans for your orthodontic care and also to maximize your benefit from insurance. Please note that the covered person’s information is needed to obtain an estimate of coverage from your dental plan. It will be held in strictest confidence.

**Please skip any information that is the same as the patient information above.**

|  |  |  |  |
| --- | --- | --- | --- |
| Responsible party: |  | Marital Status  | Single [ ]  Married [ ]  Div. [ ]  Sep. [ ]  Partner [ ]   |
|  |
| Relationship to patient:  |  |  |
| Residence |  | How long at this address? |  |
| Previous address (if less than 3 years at current address) |  |
| Mailing address (if different from residence) |  |
| Employer: |  | Occupation: |  | Years with this employer? |  |
| Contact Phone: |  | Work Phone: |  | OK to call? Y[ ]  N[ ]  |

**Dental Insurance Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Policy holder’s name |  | Birthdate  |  | SS# |  |
| Insurance Company: |  | Group # |  | ID# |  |
| Ins. Address: |  | Ins. Phone |  |
| Employer providing the policy |  | Is there dual coverage? | Y [ ]  N [ ]  |
|  |  |  |  |
| 2nd Insurance Company |  | Group # |  | ID# |  |
| Ins. Address: |  | Ins. Phone |  |
| Employer providing the policy |  |  |  |

|  |
| --- |
| I understand that a credit report may be requested for extended payment arrangements. |
| Signed: (parent if patient is a minor)  |   | Date: |  |

**Medical Questionnaire**

|  |  |  |
| --- | --- | --- |
| Name of physician: |  | Daily Medications? Y[ ]  N[ ]  |
|  If yes, please list medications: |  |
| List serious illnesses or surgeries: |  |
| Y[ ]  N[ ]  Heart disease or abnormality?Y[ ]  N[ ]  History of rheumatic fever?Y[ ]  N[ ]  Heart murmur?Y[ ]  N[ ]  Diabetes?Y[ ]  N[ ]  Hepatitis?Y[ ]  N[ ]  Anemia?Y[ ]  N[ ]  Prolonged Bleeding Tendency? Y[ ]  N[ ]  Arthritis?Y[ ]  N[ ]  Thyroid or other metabolic problem?Y[ ]  N[ ]  SmokingY[ ]  N[ ]  Frequent heartburn or gastric refluxY[ ]  N[ ]  Allergies (If yes, please list below) | Y[ ]  N[ ]  Cancer of any type?Y[ ]  N[ ]  Radiation treatment or chemotherapy?Y[ ]  N[ ]  Herpes or other STD?Y[ ]  N[ ]  HIV or other immune system disorder?Y[ ]  N[ ]  Mouth breathing?Y[ ]  N[ ]  Frequent colds or ear infections?Y[ ]  N[ ]  Frequent or severe headache?Y[ ]  N[ ]  Depression, bipolar disorder?Y[ ]  N[ ]  ADD or ADHD?Y[ ]  N[ ]  Body dysmorphic disorderY[ ]  N[ ]  Snoring?Y[ ]  N[ ]  Sleep Apnea? |
|  Please list allergies 🡪 |  |

**Dental/Orthodontic Questionnaire**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of dentist: |  | City: |  | Checkup within last 6 months | Y [ ]  N [ ]  |

|  |  |
| --- | --- |
| Y[ ]  N[ ]  Previous orthodontic treatment?Y[ ]  N[ ]  Frequent of severe tooth decay? Y[ ]  N[ ]  Gum problems or gum surgery?Y[ ]  N[ ]  Feat of dentistry?Y[ ]  N[ ]  Current dental pain?Y[ ]  N[ ]  Permanent teeth extracted?Y[ ]  N[ ]  Congenital absence of teeth?  | Y[ ]  N[ ]  Clenching or grinding habit?Y[ ]  N[ ]  Clicking or other noise in jaw joints? Y[ ]  N[ ]  Pain in jaw joints (TMJ), chewing muscles or face?Y[ ]  N[ ]  Thumb, finger or lip sucking habit at this time?Y[ ]  N[ ]  History of such habits?Y[ ]  N[ ]  History of injury to teeth or jaws? |
|  Number of soft drinks, energy drinks or sugared hot drinks per day? [ ]  1 [ ]  2 [ ]  3 [ ]  More |  Soft drink swishing habit? Y[ ]  N[ ]  |
| Is this visit for a second orthodontic opinion? Y[ ]  N[ ]  |  |

|  |
| --- |
| Dental Injury? Office use only |

**What can we help you with? (Check all that apply.)**

|  |  |
| --- | --- |
| [ ]  Crowded or misaligned teeth[ ]  Excess space between teeth[ ]  Protruding teeth[ ]  Problem with jaw size or position [ ]  Appearance of front teeth[ ]  Front teeth are too small[ ]  Difficulty chewing[ ]  Bite problems[ ]  Too little tooth shows when smiling | [ ]  Head off a developing problem[ ]  Self-consciousness about appearance of teeth[ ]  Difficulty closing lips comfortably [ ]  Slanted smile line[ ]  Too much gum tissue shows in smile[ ]  Missing teeth[ ]  Worn or chipping teeth[ ]  Dentist wants tooth movement to help with restorations |

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: (parent if patient is a minor): |  | Date: |  |