PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date_____

Patient's name _____
Last First Middle

Address _____
Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School_____ Sports/Hobbies _____

Parent or guardian name _____

Whom may we thank for referring you to our office?_____

PARENT/RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

How long at this address?_____ Home phone_____ Work phone _____

Cell/other phone_____ Email address_____

Previous Address (If less than 3 years)_____

Social Security #_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Employer's Address _____
Street City Zip

Spouse's Name_____ Relationship to Patient _____

Social Security #_____Work Phone _____

Employer_____ Occupation_____ No. years employed _____

Employer's Address _____
Street City Zip

DENTAL INSURANCE INFORMATION

Insured's Name_____ Insured's Social Security/ID # _____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

Date of Birth_____ Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security/ID # _____

Date of Birth_____

Insurance Company_____ Group No._____ Local No._____

Insurance Co. Address_____ Phone No. _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address _____
Street City Zip

Phone _____

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature _____

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____ _____

We are happy to provide you with information for your flex plan funding; please give us 6 weeks notice in the event that x-rays are needed. Thank you.

MEDICAL HISTORY

Physician _____ Date of Last Visit_____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness?_____
Yes No Has the patient had any operations? _____
Yes No Has the patient had his/her tonsils or adenoids removed?
Yes No Has the patient ever been involved in a serious accident?_____
Yes No Has the patient seen a physician in the last 12 months? Why? _____
Yes No Height of parents? Mom_____ Dad_____
Female Patients only:
Yes No Has menstruation started? _____
Yes No Is the patient pregnant? _____
Yes No Male Patients only: Has the patient's voice changed? _____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding	Dizziness	HIV/AIDS	Pneumonia
ADD/ADHD	Emotional Problems	Hormonal Imbalance	Prolonged Bleeding
Anemia	Epilepsy	Immune Deficiency	Radiation/Chemotherapy
Arthritis	Gastrointestinal Disorders	Kidney Problems	Rheumatic Fever
Asthma or Hayfever	Heart Murmur	Mental Limitations	Thyroid Problems
Autism (spectrum)	Heart Problems	Migraines	Tuberculosis
Bone Disorders	Hepatitis/Liver Problems	Nervous Disorders	Tumors/Cancer
Cerebral Palsy	Herpes	Neuromuscular Disorder	Ulcers
Diabetes	High Blood Pressure	OCD	Special Needs

Does the patient have any other medical conditions not mentioned above?_____
_____
Is the patient presently taking any medications? _____ If yes, what and for what condition?_____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What is the patient's major concern about his/her teeth? _____

Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
What is the patient's attitude toward receiving orthodontic treatment?_____
Yes No Does the patient have any type of thumb, finger or tongue habit? _____
Yes No Is the patient a mouth breather?
Yes No Has the patient complained of clicking or popping of the jaws?
Yes No Does the patient have any stiffness or soreness of the jaws or jaw muscles?
Yes No Are you aware of the patient clenching or grinding teeth?
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any trauma or injuries to the face, mouth, or teeth? _____
Yes No Has the patient had episodes where the jaw would not open or close normally?
Yes No Does the patient experience "tension" headaches?
Yes No Has the patient ever experienced chronic ringing in the ears?
Yes No Has the patient ever had any unfavorable dental experiences? _____
Yes No Does the patient need extra help with instructions? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Martin to perform a complete orthodontic evaluation.

Signature: Date: _____

Yes No Are you aware that some appointments will be during school hours?