Date ___________________

Confidential Patient Information

A B C

Patient's Name_____________________________________ Preferred name/Nickname _______________
Last First
Address____
Street City State Zip
Home Phone____________________ Birthdate __________ Patients Age______ Male __ Female __

How long at this address? _______ Own or Rent Social Security #_________________

Employer ____________________ Occupation ____________________ No. Years Employed ________

General Dentist ___________________ Physician _________ Email_____________________________

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

How did you hear about our office? Insurance [ ] Dentist [ ] Patient [ ] ____________ Other [ ] ___________

Financially Responsible Party Information

Name____ Marital Status________
Last First Middle

Address ____ Own Rent
Street City State Zip

How long at this address____________ Home Phone________________ Work Phone________________

Cell Phone ____________________ E-mail address ____

Previous Address (if less than 3 yrs.)____
Street City State Zip

Social Security #_________________ Birthdate_________________ Relationship to Patient_____________

Employer______________________ Occupation_______________ No. Years Employed_______________

Spouse's Name____ Relationship to Patient_____________
Last First Middle

Employer______________________ Occupation_______________ No. Years Employed_______________

Social Security #_________________ Birthdate_________________ Work Phone_________________

Cell Phone ____________________ E-mail address ____

Dental Insurance Information

Policy Holder's Name____________________ SS #_____________________Birthdate _______________

Address ____
Street City State Zip
Insurance Company___________________________ Group No.__________ Union Local No.____________

Insurance Co. Address_____________________________________ Insurance Co. Phone______________

Policy Holder's Employer____________________________________*Relationship to Patient*______________

Do you have dual coverage? No ☐ Yes ☐

Policy Holder's Name____________________ SS #_____________________Birthdate _______________

Address ____
Street City State Zip
Insurance Company___________________________ Group No.__________ Union Local No.____________

Insurance Co. Address_____________________________________ Insurance Co. Phone______________

Policy Holder's Employer____________________________________*Relationship to Patient*______________

Please See Back

For office use only:
__ Add referral into Oasys __ Mail TY note to referral
__ Record GC in referral log
__ Send dentist letter __ Update Status __ Set up recall

MEDICAL HISTORY:

1) Is patient in good health? YES____ NO____ HEIGHT: ______ WEIGHT: ______

2) Does patient have any history of major illness? YES____ NO____ Please explain: ____________________

3) Has the patient been treated for the following:

	YES	NO
Asthma		
Anemia		
Autism		
Bone Disorders		
Diabetes		
Endocrine Problems		
Epilepsy		
Fainting or Dizziness		
Heart Trouble		
HIV+/Aids		
Kidney Involvement		
Liver Involvement		
Nervous Disorders		
Pneumonia		
Prolonged Bleeding		
Rheumatic Fever		
Tuberculosis		

Other: (please explain)
____
____
____
____

If patient has heart condition, is pre-medication required for dental work?

____

4) Have Tonsils and Adenoids been removed? YES____ NO____ If yes, what age? ________

5) List any drugs or medications now being taken, give reasons: ______________________________________

6) Is premedication required before starting dental procedures? YES____ NO____

7) List any allergies or drug sensitivity: ____

DENTAL HISTORY:

1) Have there been any injuries to the face, mouth or teeth? YES____ NO____
If yes, please explain: ____________________________

2) Has the patient ever sucked a thumb or fingers? YES____ NO____
If yes, until what age? ___________________________

3) Does the patient have any speech problems? YES____ NO____

4) Have you been informed of any missing or extra permanent teeth? YES____ NO____

5) Has an Orthodontist been consulted previously? YES____ NO____

6) Has either parent had orthodontic treatment? YES____ NO____

7) List any musical instruments played: ____

REASON FOR CONSULTATION: ____
____
____

I understand that the information that I have given 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 patient's medical status. I also authorize the dental staff to perform the necessary orthodontic services as needed. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. This office reserves the right to verify the credit status of potential patients and or/parents prior to extending credit for treatment fees. I understand that where appropriate, credit bureau reports will be obtained.

Patient/Parent/Guardian Signature _________________________________

Print Name ____

Updates (date & initial) ____

A copy of your driver's license and insurance card will be required at your initial visit.