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We would like to welcome you to our office. Our goal is to make every patient's visit pleasant and educational. We strive to teach good oral care that will enable our patient to have a beautiful smile that lasts a lifetime.

1 Tell Us About The Patient

Today's Date: ______________________

Patient Name: ______________________
LAST FIRST MI

Nickname: ______________________

Patient Birthdate ___/___/___ Sex:____ Age:____

School: ______________ Grade: ________

Hobbies/Sports: ______________________

Patient Home #: ______________________

Patient Home Address: ______________________

____
CITY STATE ZIP

2 Who Is Accompanying Patient Today?

Name: ______________ Relation: ________

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you? ________

List family members we have treated: ________

____

____

General Dentist: ______________________

Last Visit Date: ______________________

3

Mother's Information: ❑ Step Mother ❑ Guardian

Name: ______________________

WK #: ____________ Ext: ____ HM #: ________

Employer: ______________________

Father's Information: ❑ Step Father ❑ Guardian

Name: ______________________

WK #: ____________ Ext: ____ HM #: ________

Employer: ______________________

Parent's Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

4 Person Responsible for Account

Name: ______________ Relation: ________

Billing Address: ______________________

____
CITY STATE ZIP

WK #: ____________ Ext. ____ HM #: ________

Cell Phone #: ______________________

Employer: ______________________

Who is responsible for making appointments?

Name: ______________________

WK #: ____________ Ext. ____ HM #: ________

Cell Phone #: ______________________

5 Primary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local, or Policy) #: ________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured's Birthday: ___/___/___ & SS #: ________

Insured's Employer: ______________________

Secondary Orthodontic Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local, or Policy) #: ________

Insured's Name: ______________________

Relationship to Patient: ______________________

Insured's Birthday: ___/___/___ & SS #: ________

Insured's Employer: ______________________

6 General Information

What is your main orthodontic concern? ____________

____

Has the patient ever been evaluated or had orthodontic treatment before? ❑ Yes ❑ No

Has there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played. ____________

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has the patient been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has the patient ever had any pain/tenderness in his jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does patient brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Physician: ____________

Phone #: ____________ Date of Last Visit: ____________

Is patient currently under the care of a physician? ❑ Yes ❑ No

Please describe the patient's current physical health: ❑ Good ❑ Fair

Please list all drugs that the patient is currently taking:

____

Please list all drugs that the patient is allergic to:

____

7 Has The Patient Ever Had Any Of The Following Medical Problems?

Y	N	Allergic to Plastic	Y	N	Allergic to Latex/Metals
Y	N	Heart Murmur	Y	N	Congenital Heart Defect
Y	N	Cancer	Y	N	Convulsions/Epilepsy
Y	N	Diabetes	Y	N	Abnormal Bleeding
Y	N	Rheumatic Fever	Y	N	Hearing Impairment
Y	N	HIV+ / AIDS	Y	N	Any Operations
Y	N	Hemophilia	Y	N	Any stays in a hospital
Y	N	Asthma	Y	N	Kidney/Liver Problems
Y	N	Hepatitis	Y	N	Handicaps/Disabilities
Y	N	Tuberculosis (TB)	Y	N	Allergies to any Drugs
Y	N	Artificial Prosthesis	Y	N	Mental Challenges

Please discuss any medical problems that patient has had or any categories that required a yes answer:

____

____

____

8 Does or Did The Patient Have Any Of The Following Habits?

Y	N	Thumb/Finger Sucking	Y	N	Mouth Breather
Y	N	Lip Sucking/Biting	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Nail Biting
Y	N	Nursing Bottle Habits	Y	N	Tongue Thrust

comments: ____________

9 Classification

For Office Use Only

Class I ____________

ANGLE ________ II Div. I ________ Sub: R. L. ________

________ II Div. II ________ Sub: R. L. ________

________ III ________ Sub: R. L. ________

Mutilated ____________

Clinical Observation: ____________

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Intra-Oral X-Rays ______ Models ______

Ceph. X-Rays ______ Photographs ______

10 Financial Arrangements

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11 Consultation

Date: ____________

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Signature of Responsible Party ____________

Date ____________

Signature of Orthodontist ____________

Date ____________