

1. ABOUT YOU

DATE _____

Name _____ I prefer to be called _____

Gender/Sex _____ Gender/Sex at Birth _____

Email address _____ Birth date _____ Social Security _____

Home Address _____

City _____ State _____ Zip _____

Single Married Divorced Widowed Separated

Home # _____ Work# _____ Cell# _____

Employer _____ How long there? _____ Occupation _____

Other family members seen by us? _____

Who may we thank for referring you? _____

General Dentist: _____ Date of last visit: _____

2. SPOUSE INFORMATION

Name _____ Birth date _____ Social Security _____

Employer _____ How long there? _____ Occupation _____

3. INSURANCE INFORMATION

PRIMARY

Insured's Name _____ Insured's SS# _____

Relationship to patient _____

Insurance Company _____ Group # _____ Phone _____

Insured's Employer _____ Insured's Date of Birth _____

Address of Insured _____ City _____ State _____ Zip _____

SECONDARY

Insured's Name _____ Insured's SS# _____

Relationship to patient _____

Insurance Company _____ Group # _____ Phone _____

Insured's Employer _____ Insured's Date of Birth _____

In the event of an emergency is there someone who lives near you that we should contact?

Name _____ Relationship to patient _____ Phone _____

4. MEDICAL HISTORY

Are you currently under the care of a physician? Yes No Please explain: _____

Physician's Name _____ Phone #: _____ Date of Last Visit: _____

Are you currently taking any medication? Please list each one: _____

Are you allergic to: Latex Plastics / Metals Aspirin Penicillin Other _____

For Women: Are you pregnant? Yes No If yes, weeks _____ Are you nursing? Yes No

Have you ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Epilepsy / Seizures / Fainting	Y N Psychiatric Problems
Y N Anemia	Y N Fever Blisters / Herpes	Y N Rheumatic / Scarlet Fever
Y N Artificial Bones / Joints / Valves	Y N Glaucoma	Y N Severe / Frequent Headaches
Y N Asthma / Arthritis	Y N Heart Condition	Y N Shingles
Y N Blood Transfusion	Y N Hepatitis	Y N Sickle Cell Disease
Y N Cancer / Chemotherapy	Y N High / Low Blood Pressure	Y N Sinus Problems / Difficulty Breathing
Y N Congenital Heart Defect	Y N HIV+ / AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Ulcers
Y N Drug / Alcohol Abuse	Y N Mitral Valve Prolapse	Y N Venereal Disease
Y N Emphysema	Y N TMJ	

5. DENTAL HISTORY

What treatment goals would you like to accomplish? _____

Have you ever been evaluated by an orthodontist before? Yes No

Have you ever experienced TMJ pain? Yes No

Have you been informed of missing or extra teeth? Yes No

Have you had injury to your mouth, chin or teeth? Yes No

Your current dental health is Good Fair Poor

Have you ever taken Fosamax or any other bisphosphonate? Yes No

Have you ever taken Phen-Fen? Yes No

Do you generally breathe through your mouth? If yes, please circle: While Awake? While Asleep?

I understand that the information given is correct to the best of my knowledge.

I also understand that where appropriate, a credit report may be obtained.

Signature _____ Date _____