Date: _____

PATIENT INFORMATION

Patient's Name:

_____

Last First

MI Nickname

Address:

_____

Street City

State Zip

Home Phone: _____ Cell Phone/Carrier: _____ Email: _____

DOB: _____ Sex: _____ General Dentist: _____ SS No: _____

Whom may we thank for referring you to our office?

_____

If patient is a minor, please complete

School: _____ Hobbies: _____

RESPONSIBLE PARTY INFORMATION

Please skip this step if information is the same as above

Name:

_____

Last First

MI Nickname

Address:

_____

Street City

State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

SS No: _____ DOB: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ Years Employed: _____

Spouse's Name: _____ Relationship to Patient: _____

SS No: _____ DOB: _____ Cell Phone: _____

Employer: _____ Occupation: _____ Years Employed: _____

DENTAL INSURANCE INFORMATION

Insured's Name: _____ Insured's SS No: _____ Insured's DOB:_____

Insurance Co: _____ Group No: _____ Phone: _____

Insurance Address: _____

Do you have dual coverage? _____ If yes:

Insured's Name: _____ Insured's SS No: _____ Insured's DOB:_____

Insurance Co: _____ Group No: _____ Phone: _____

Insurance Address: _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Address: _____

DENTAL HISTORY

Date of last dental check-up: _____ Height of Parents: Mom _____ Dad _____

What concerns you most about your teeth?
_____

Y N Is the patient presently in any dental pain?

Y N Has the patient ever lost or chipped any teeth

Y N Have there been any injuries to the face, mouth, or teeth?

Y N Do your gums ever bleed?

Y N Do you have any missing, extra, or impacted teeth?

Y N Do your teeth or jaw feel uncomfortable first thing in the morning?

Y N Do you have any jaw clicking or popping?

Y N Do you experience “tension” headaches?

Y N Is the patient self-conscious or sensitive about his/her teeth?

Y N Does the patient need extra help with instructions?

Y N Are you aware that some appointments will be during school hours?

Y N Have you ever been evaluated or had orthodontic treatment? If yes, who and when _____

Y N Has anyone in the family received orthodontic treatment? If yes, how did they feel about the results? _____

HABITS

Did you or do you have any of the following habits?

Y N Clenching/grinding teeth

Y N Lip sucking/biting

Y N Thumb/finger sucking

Y N Nail biting

Y N Mouth breather

Y N Tongue thrust

MEDICAL HISTORY

Physician: _____ Phone: _____ Date of Last Visit: _____

Y N Has the patient ever been involved in a serious accident?

Y N Has the patient had any operations?

Y N Is there a family history of any major illnesses?

Y N Is the patient taking ANY MEDICATION? If so, what:
_____

Y N Is the patient ALLERGIC to any medication? If so, what:
_____

For females only:

Y N Has menstruation started?

Y N Is the patient pregnant?

Y N Is the patient taking birth control pills?

Please circle any of the medical conditions below that the patient has previously had or currently has:

Abnormal bleeding/ Hemophilia	Diabetes	Hepatitis/Liver Problems	Prolonged Bleeding
Anemia	Dizziness	High Blood Pressure	Radiation/ Chemotherapy
Arthritis	Epilepsy	HIV/AIDS	Rheumatic Fever
Asthma/Hay fever	Gastrointestinal Disorders	Kidney Problems	Tuberculosis
Bone Disorders	Heart problems/Murmurs	Nervous Disorders	Tumor/Cancer

BENEFITS

Benefits of Orthodontics: Aesthetics, health and function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in 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 agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Podray to perform a complete orthodontic evaluation.

Signature (Patient/Guardian of Minor): _____ Date: _____

I hereby state that the information on this form is true and correct to the best of my knowledge and understand that where appropriate, credit bureau reports may be obtained. I agree to allow Dr. Podray to contact my family dentist, physician, and other health care professionals as required to permit proper treatment.

Signature (Patient/Guardian of Minor): _____ Date: _____