

Financially Responsible Party Information

Ms. Miss Married Separated
 Name Mrs. Mr. Dr. _____ Single Divorced
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Do you have orthodontic coverage? Yes No Benefit amount: _____ If no, please skip this section.

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No. _____

Insured's Employer Address _____

Insurance Company Name & Address _____

Insurance Company Phone Number _____

Secondary insurance? Yes No Benefit amount: _____ If no, please skip this section.

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Employer _____ Group No. _____ Local No. _____

Insured's Employer Address _____

Insurance Company Name & Address _____

Insurance Company Phone Number _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and records for treatment rendered to me or my child if necessary for insurance purposes. I also authorize direct payment of insurance benefits to the dentist for services rendered when indicated.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

Patient Information

A B C

Date _____

Patient's Name _____ Soc. Sec. # _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____

Patient Work Phone _____ *If a minor, give parent or guardian's name* _____

General Dentist _____ Physician _____

Oral Surgeon _____ *Whom may we thank for referring you?* _____

Reason for consultation _____

Have you ever been examined by an orthodontist? _____ *If yes, when?* _____ *Had Braces?* _____

Siblings' name and age _____

Medical Information

Is patient in good health? Yes _____ No _____

Does patient have any history of major illness? Yes _____ No _____

Has patient ever been under the care of a physician for illness? Yes _____ No _____

If yes, give reason _____

Check any of the following for which the patient has been treated or diagnosed with:

Heart Complications	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	A.I.D.S.	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	H.I.V. Positive	<input type="checkbox"/>	Bone Disorders	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	Herpes/Cold Sores	<input type="checkbox"/>
Arthritis / Rheumatism	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Hemophilia/Prolonged Bleeding	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Kidney Complications	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	Periodontal Disease	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	Endocrine Problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	Liver Involvement	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	Nervous/Anxious	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>

Does patient have a tendency to colds? YES NO Sore Throats? YES NO Ear Infections? YES NO

Have tonsils and/or adenoids been removed? YES NO At what age? _____

List any drugs or medications now being taken and give reasons _____

List any allergies or drug sensitivity _____

Dental History

Have you had any injuries to the face, mouth or teeth? YES NO

Habits: Thumb or Finger Sucking YES NO

 Mouth Breathing YES NO

 Nail/Lip Biting YES NO

 Grinding or Clenching of Teeth YES NO

Have you been informed of any missing or extra permanent teeth? YES NO