Patient Information Form

Please complete both sides of this form and bring it with you to your appointment. Thank you!

General Information

Date | *Birthdate* | *Social Security Number*

Last Name | *First Name* | *Middle Name*

Street Address | *City* | *State* | *Zip*

Home Phone | *Parent/Guardian's Name (if a minor)* | *Whom may we thank for referring you?*

Responsible Party Information

Last Name | *First Name* | *Middle Name* | *Marital Status*

Street Address | *City* | *State* | *Zip*

How long at this address? | *Home Phone* | *Work Phone*

Previous Street Address (if less than 3yrs) | *City* | *State* | *Zip*

Relationship to Patient | *Birthdate* | *Social Security Number*

Employer | *Occupation* | *No. Years Employed*

Spouse's Last Name | *Spouse's First Name* | *Spouse's Middle Name*

Spouse's Employer | *Spouse's Occupation* | *Spouse's Work Phone*

Insurance Information

Insured's Name | *Insured's Soc. Sec. #*

Insurance Company | *Group No.* | *Local No.*

Insurance Co. Street Address | *City* | *State* | *Zip*

Do you have dual coverage? ❑Yes ❑No If yes:

Insured's Name | *Insured's Social Security Number* | *Insured's Employer*

Insurance Company | *Group No.* | *Local No.*

Insurance Co. Street Address | *City* | *State* | *Zip*

Emergency Information

Name of the nearest relative not living with you | *Phone Number*

Street Address | *City* | *State* | *Zip*

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's if minor)

Updates (date & initial) | *Updates (date & initial)* | *Updates (date & initial)* | *Updates (date & initial)* | *Updates (date & initial)*

Miscellaneous

_____

Hobbies & Interests

_____

School

_____ _____

Brothers (w/ages) *Sisters (w/ages)*

Patient Living with: ❑Mother ❑Father ❑Self ❑Other:_____

Medical History

Family Physician:_____

Has the patient ever had any serious medical problem? ❑Yes ❑No Describe:_____

_____

Has the patient ever had any of the following?

Asthma	❑Yes ❑No	Heart Murmur	❑Yes ❑No	Endocrine Problems	❑Yes ❑No
Anemia	❑Yes ❑No	Chronic Cough	❑Yes ❑No	Thyroid Problems	❑Yes ❑No
AIDS OR HIV+	❑Yes ❑No	Tuberculosis	❑Yes ❑No	Heart Disease/Disorder	❑Yes ❑No
Arthritis	❑Yes ❑No	Coughed Up Blood	❑Yes ❑No	Rheumatic Fever/Disease	❑Yes ❑No
Cancer	❑Yes ❑No	Kidney Problems	❑Yes ❑No	Excessive Bleeding	❑Yes ❑No
Chest Pain	❑Yes ❑No	Lung Problems	❑Yes ❑No	Abnormal Blood Pressure	❑Yes ❑No
Diabetes	❑Yes ❑No	Liver Disease	❑Yes ❑No	Breathing Problems	❑Yes ❑No
Epilepsy	❑Yes ❑No	Bone Disorder	❑Yes ❑No	Nervous Disorder	❑Yes ❑No
Herpes	❑Yes ❑No	Blood Disease	❑Yes ❑No	Fainting/Dizziness	❑Yes ❑No
Hepatitis	❑Yes ❑No	Hearing Disorder	❑Yes ❑No	Emotional Problems	❑Yes ❑No
Jaundice	❑Yes ❑No	X-Ray Treatment	❑Yes ❑No	Other (describe below)	❑Yes ❑No

Has the patient taken any kind of medicine or drugs during the past year? ❑Yes ❑No Name of drug:_____

_____

Has the patient been under the care of a physician during the past two years, other than for routine examination?
❑Yes ❑No If yes, please describe:_____
Comments:_____

_____

If the patient is female, is she pregnant now? ❑Yes ❑No

Does the patient:

Have allergies to: Seasonal grasses? ❑Yes ❑No Drugs? ❑Yes ❑No Which?_____
Foods? ❑Yes ❑No Other? ❑Yes ❑No_____
Breathe through mouth? ❑Yes ❑No ❑Sometimes
Have Sinus troubles? ❑Yes ❑No
Susceptable to colds, sore throats, ear infections? ❑Yes ❑No
Tonsils removed? ❑Yes ❑No When?_____
Adenoids removed? ❑Yes ❑No When?_____

Dental History

Family Dentist:_____

Date of last dental check-up:_____ Were the patient's teeth cleaned? ❑Yes ❑No
Have any teeth been injured due to accidents or blows to the mouth? ❑Yes ❑No
Has the patient ever sucked a thumb or finger? ❑Yes ❑No If so, until what age?___
Have you been informed of any missing or extra permanent teeth? ❑Yes ❑No
Have you been informed of any gum problems or disease? ❑Yes ❑No
Has the patient had cankers or cold sores on the lips, tongue, gums, or body? ❑Yes ❑No
Has the patient had previous orthodontic consultation? ❑Yes ❑No
Treatment? ❑Yes ❑No Date:_____Doctor:_____
What is the primary problem or concern?_____
Comments:_____