

## Patient Information

For office use: Taken by \_\_\_\_\_ Today's date \_\_\_\_\_ Patient # \_\_\_\_\_ Exam date \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ Int. \_\_\_\_\_ Nickname \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

**Parent or Self** \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone # \_\_\_\_\_  
Occupation \_\_\_\_\_ Dental insurance company \_\_\_\_\_  
Insurance phone # \_\_\_\_\_ Group # \_\_\_\_\_ Orthodontic benefit \_\_\_\_\_

**Parent or Spouse** \_\_\_\_\_ Birthday \_\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone # \_\_\_\_\_  
Occupation \_\_\_\_\_ Dental insurance company \_\_\_\_\_  
Insurance phone # \_\_\_\_\_ Group # \_\_\_\_\_ Orthodontic benefit \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_  
Names and ages of siblings \_\_\_\_\_ Friends or relatives here? \_\_\_\_\_

## Medical and Dental Information

**Patient's Dentist:** \_\_\_\_\_ Phone # \_\_\_\_\_ Date of last check up \_\_\_\_\_  
History of injuries to the patients face, mouth or teeth? Yes  No  Please describe \_\_\_\_\_  
For office Use: Pano \_\_\_\_\_ Perio chart \_\_\_\_\_ Remaining treatment or concerns \_\_\_\_\_

**Patient's Physician:** \_\_\_\_\_ Phone # \_\_\_\_\_  
Patient's Health: Excellent  Good  Fair  Poor  Medical conditions we should know about? Yes  No   
Describe \_\_\_\_\_  
Allergies? \_\_\_\_\_ Tonsils or adenoids removed? Yes  No  What age? \_\_\_\_\_  
Medications currently taking \_\_\_\_\_ Drug sensitivities? \_\_\_\_\_

Check any of the following for which the patient has been treated

- |   |   |  |   |                                       |
|---|---|--|---|---------------------------------------|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Nervous disorder   | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Heart trouble         | <input type="checkbox"/> Pneumonia          |                                       |
| <input type="checkbox"/> Bone disorders | <input type="checkbox"/> Endocrine problems | <input type="checkbox"/> Kidney involvement    | <input type="checkbox"/> Prolonged bleeding |                                       |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Liver involvement     | <input type="checkbox"/> Rheumatic fever    |                                       |

## Emergency Contact

Friend or nearest relative \_\_\_\_\_ Phone # \_\_\_\_\_

## Responsible Party Information

Person responsible for account \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home phone# \_\_\_\_\_ Work phone# \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_