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

☐ Anemia	☐ Diabetes	☐ Fainting or dizziness	☐ Nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Emotional problems	☐ Heart trouble	☐ Pneumonia	
☐ Bone disorders	☐ Endocrine problems	☐ Kidney involvement	☐ Prolonged bleeding	
☐ Cerebral palsy	☐ Epilepsy	☐ Liver involvement	☐ 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_____