ADULT PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Name _____

Prefer to be called _____ Birthday ____/_____/_____ Age _____ Sex ____
month day year

e-mail _____

Home Address _____ City _____ State ____ Zip _____

Cell Phone _____ Work/Home Phone _____

Occupation _____ Employer _____

Patient fluent in the following languages _____

Has any member of your family been treated by this office? Y/N/WHOM _____

Who may we thank for referring you to our office? _____

Marital Status _____ Do you have any children? Y/N

Children's names and birthdates: _____

Patient's Dentist _____ Patient's Physician _____

Date of last dental cleaning at the Dentist ____/____
month year

Is there any pending dental work at the Dentist? _____

BILLING INFORMATION

If responsible party is other than self, fill out the following questions:

Person responsible for this account:

Last Name _____ First Name _____ Middle Name _____

SS# _____ Relationship to patient _____

Billing Address _____ City _____ Zip _____

Occupation _____ Cell phone _____ Work phone _____

Employer's Name _____

INSURANCE INFORMATION

Is patient covered by orthodontic insurance? Y/N

Name of Policy Holder _____ Relationship to Patient _____

Dental insurance company _____ Insured's DOB ____/____/____
month day year

SS# Insured: _____ 1-(800) _____

Group Name: _____ Group #: _____

Signature_____ **Date**_____

MINOR PATIENT INFORMATION

Date _____

Last Name _____ First Name _____ Middle Name _____

Preferred to be called _____ Birthday ____/____/____ Age_____ Sex ___
month day year

Home Address _____ City _____ State ____ Zip _____

Home Phone _____ School _____ Grade _____

Mom/Dad e-mail _____

Patient's Dentist _____ Patient's Pediatrician _____

Date of last dental cleaning at the Dentist ____/____
month year

Is there any pending dental work at the Dentist? _____

Patient fluent in the following languages _____

Has any member of your family been treated by this office? Y/N/WHOM _____

Who may we thank for referring you to our office? _____

Mother's Name _____ Occupation _____ Cell phone _____

Father's Name _____ Occupation _____ Cell phone _____

Mom’s spoken languages _____ Dad’s spoken languages _____

BILLING INFORMATION

Person responsible for this account:
Last _____ First _____ Middle _____

SS# _____ Relationship to patient _____

Billing Address _____ City _____ Zip_____

Cell phone _____ Work phone _____

Employer's Name _____

INSURANCE

Is patient covered by orthodontic insurance? Y/N

Name of Policy Holder _____ Relationship to Patient _____

Dental Insurance company _____ Insured’s DOB ____/____/____
month day year

SS# Insured:_____ 1-(800)_____

Group Name: _____ Group #:_____

Signature_____ **Date**_____

MEDICAL HISTORY

Are you under the care of a physician for any specific condition? ☐Yes ☐No

If yes, please describe _____

Are you currently taking any medications? ☐Yes ☐No

If yes, please list _____

Please circle if you have or have had any of the following :

Heart Murmur	No Yes	Hepatitis	No Yes
AIDS/HIV Positive	No Yes	Diabetes	No Yes
Blood Pressure Problems	No Yes	Endocrine or Growth Problems	No Yes
Tuberculosis	No Yes	Convulsions or Epilepsy	No Yes
Tonsillitis	No Yes	Artificial joints or heart valves	No Yes
Difficulty breathing	No Yes	Allergies	No Yes
Asthma or Hayfever	No Yes	Headaches	No Yes