WELCOME TO THE ORTHODONTIST

REFERRED BY: _____ FAMILY DENTIST: _____

PATIENT INFORMATION

PATIENT'S NAME:_____ EMPLOYMENT:_____

HOME PHONE:_____ OCCUPATION:_____

DATE OF BIRTH:_____ WORK PHONE:_____

AGE:_____ MARITAL STATUS:_____

PATIENT'S HOME ADDRESS

STREET:_____ SPOUSE'S NAME:_____

CITY & ZIP:_____ EMERGENCY CONTACT INFORMATION:_____

EMAIL:_____ _____

PATIENT'S PHYSICIAN:_____ _____

INSURANCE INFORMATION: (MUST SUPPLY ALL INFORMATION FOR INSURANCE TO BE SUBMITTED)

DO YOU HAVE **ORTHODONTIC** COVERAGE? (PLEASE CIRCLE ONE) YES NO

INSURED'S FULL NAME:_____ SSN/ID#:_____

INSURED'S EMPLOYER:_____

INSURANCE CO. NAME:_____ INS CO PHONE #:_____

MEDICAL INFORMATION: (PLEASE CIRCLE ALL THAT APPLY)

HIV POSTITIVE OR AIDS	HEART MURMUR	CONGENITAL HEART DEFECT	THUMB SUCKING
DIABETES	EPILEPSY	HANDICAPS OR DISABILITIES	CLENCHING TEETH
RHEUMATIC FEVER	ABNORMAL BLEEDING	HEPATITIS	MOUTH BREATHER
ALLERGIES	HEARING PROBLEMS	TUBERCULOSIS	TOUNGE THRUST
ALLERGIES TO MEDICINE	KIDNEY/LIVER PROBLEMS	CANCER	SPEECH PROBLEMS
NERVOUS PROBLEMS	VENEREAL DISEASE	ASTHMA	HEADACHES

ARE YOU CURRENTLY TAKING ANY MEDICATION? _____

ALLERGIES: (PLEASE CIRCLE ALL THAT APPLY)

ALLERGIES TO FOOD ALLERGIES TO MEDICINE ALLERGIES TO LATEX ALLERGIES TO METAL

PLEASE EXPLAIN ANY OF THE ABOVE INCLUDING ALLERGIES AND ANY SURGICAL PROCEDURES: _____

_____

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I ALSO AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVIES THAT I MAY NEED.

SIGNATURE OF PATIENT:_____DATE:_____