



Patient Information

Today's Date _____
Patient's Name _____ Nick Name _____
Address _____ City _____ Zip _____
Email Address _____ Home Phone _____ Cell Phone _____
SSN _____ D/O/B ____/____/____ Age _____ Sex _____
School _____ Grade _____ Hobbies/Interests _____
General/Pediatric Dentist _____ City _____ Last Visit _____
Whom may we thank for referring you to our office? _____
Siblings: Name/Age _____

Responsible Party Information

Father's Name _____ Biological Other _____
Address _____ City _____ How Long? _____
Email Address _____ Work Phone _____ Home Phone _____ Cell Phone _____
SSN ____/____/____ D/O/B ____/____/____
Employer _____ Occupation _____ How Long? _____
Mother's Name _____ Biological Other _____
Address _____ City _____ How Long? _____
Email Address _____ Work Phone _____ Home Phone _____ Cell Phone _____
SSN ____/____/____ D/O/B ____/____/____
Employer _____ Occupation _____ How Long? _____
Person financially responsible for this account _____

Orthodontic Insurance Information

Primary Dental Insurance Orthodontic Coverage? Yes No
Insured's Name _____ Relation: _____ Employer _____
DOB ____/____/____ SSN _____
Insurance Company _____ Group No. _____ ID No. _____
Insurance Company Address _____ City _____ Zip _____
Insurance Company Phone _____
Do you have dual coverage? Yes No
Secondary Dental Insurance Orthodontic Coverage? Yes No
Insured's Name _____ Relation: _____ Employer _____
DOB ____/____/____ SSN _____
Insurance Company _____ Group No. _____ ID No. _____
Insurance Company Address _____ City _____ Zip _____
Insurance Company Phone _____

Emergency Information

Contact Person _____ Relation _____ Phone _____

Medical History

Physician's Name _____ Last Visit _____ Phone Number _____

Current physical condition Good Fair Poor Currently under the care of a physician? Yes No

Ever been under the care of a physician for a major illness? Yes No _____

Please answer all questions by checking "Yes" or "No".

Good health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent cold, cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart or chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle cell anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hay fever, seasonal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nasal obstruction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Severe headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Herpes (cold sores)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bone disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Endocrine disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Canker sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Growth disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Antibiotics required for dental appointments	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tonsils/Adenoids removed	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Still growing	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

List any drugs (prescription and over the counter) that you are currently taking and please give reason _____

List any allergies or sensitivities including drug, latex, metal or other _____

Has patient reached puberty? Girl – Started menstruation Yes No _____
 Boy – Voice changed/facial hair Yes No _____

Dental History

What are the main concerns you would like orthodontics to accomplish? _____

Current dental health Good Fair Poor

Has an orthodontist been consulted previously? Yes No Ever been treated with orthodontic treatment before? Yes No
If yes, please explain: _____

Family history of orthodontic treatment Yes No _____

Has patient ever sucked a thumb or finger? Yes No If yes, until what age? _____

Has your child ever experienced pain / discomfort in jaw joint (TMJ/TMD)? Yes No

Does your child have a tongue thrust? Yes No Any history of speech problems? Yes No

Has your child ever had injuries to face, mouth, teeth or chin? Yes No

Does your child generally breath through their mouth? Awake: Yes No Asleep Yes No

Does your child have any missing or extra permanent teeth? Yes No _____

I have read and understand the above questions. I will not hold Dr. Newman or Dr. McNamara or any member of their staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature _____ Date _____