

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 _____