PATIENT HISTORY **Today's date_____**

Patient name_____Sex_____Birthdate_____
Address_____City, State, Zip_____
Home phone_____ Family Cell phone# _____
Parents Email address_____Dentist name _____
Whom may we thank for referring you to our office? Dentist_____Friend_____Self_____
Who will be responsible for this account?_____

RESPONSIBLE PARTY INFORMATION: (fill out for minors only)

Father's Name_____Address_____
Birthdate_____Home phone _____Work phone _____
Employer & Occupation_____ Social Security #_____
Mother's Name_____ Address _____
Birthdate_____Home phone _____Work phone _____
Employer & Occupation_____ Social Security #_____

DENTAL INSURANCE

Insured Name_____Insured Social Security #_____
Insurance Company_____Group No._____Local No._____
Insurance Co. Address_____phone _____
Do you have dual coverage Yes_____ No_____ If yes:
Insured Name _____Insured Social Security #_____
Insurance Company_____ Group No. _____Local No._____
Insurance Co. Address_____phone _____

HEALTH HISTORY

Have you ever had orthodontic treatment before?_____Date of last dental exam_____
Problem you are wanting corrected_____
Physician Name_____Address_____phone_____

Circle any of the medical conditions below that you have had or currently have:

Cancer	Hepatitis	HIV/Aids
Congenital heart defect	Tuberculosis	Epilepsy/Convulsions
Bleeding Disorders	Heart Murmur	Asthma

Are there any other medical conditions we have not listed that you feel we should be aware of? _____
_____

Please circle Yes or No (If yes, please fill in details below)

Yes No Are you taking any medication?_____
Yes No Are you allergic to any medication?_____
Yes No Have you ever been involved in any serious accident?_____

DENTAL HISTORY

Yes No Are you presently in any dental pain?
Yes No Have you ever lost or chipped a tooth?
Yes No Have you ever had any injuries to face, mouth or teeth?
Yes No Do your gums bleed?
Yes No Do you have any type of thumb or tongue habit?
Yes No Are you a mouth breather?
Yes No Have you ever seen an orthodontist: If yes, Who and When_____
Yes No Has anyone in your family received orthodontic treatment?
Yes No Does your jaw click or pop?
Yes No Do you clench or grind your teeth?
Yes No Do you have tension headaches?
Yes No Are you aware that some of your appointments will be during school/work?

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or my child's) health. It is my responsibility to inform the dental office of any changes in my (or my child's) medical status. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize insurance payment benefits payable to me directly to the doctor.

X_____Date_____

Signature of patient (or parent or guardian if a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of our privacy practice information is available from our office. Please read through this at your first visit and then sign below.

I, _____ have read a copy of the office's Notice of Privacy Practices.

_____

Please print name

_____

Signature

_____

Date