Welcome To The Orthodontist

Confidential Patient Information Form

Patient Name _____ Birthdate _____ Phone_____

Address _____ City_____ State _____ Zip _____

Family Dentist _____ Date of Last Visit ____/___/_____ SS# _____-_____-_____

Employer _____ Occupation _____ Business Phone _____

How did you hear about our office? _____

In your words, what is the problem? _____

Have you seen another orthodontist? _____ Any orthodontic treatment? _____

Any other family members in treatment here? _____Who? _____

CHECK any of the following which you have had or still have at present:

☐ Frequent Headaches	☐ Fainting/ Dizzy Spells	☐ Mouth Breathing
☐ Anemia/Bleeding Disorder	☐ Head Trauma	☐ Tongue Thrust
☐ Heart Murmur	☐ Tonsils/Adenoids Removed	☐ Speech Problems
☐ High Blood Pressure	☐ Hepatitis A , C	☐ Lip Biting
☐ Kidney Trouble	☐ Hepatitis B	☐ Nail Biting
☐ Diabetes	☐ AIDS or HIV+	☐ Teeth Clenching
☐ Tuberculosis	☐ Earaches	☐ Teeth Grinding
☐ Asthma/Hay Fever	☐ Allergies: please list _____	☐ Difficulty Opening Wide
☐ Sinus Infection	_____	☐ Clicking or Popping in Jaw Joint
☐ Epilepsy/Seizures	_____	☐ Pain in the Jaw Joint

Any other serious health condition we should know about? _____

Any medications taken regularly? _____List_____

What are your concerns with orthodontic treatment? _____

Additional Contact Person

Name _____ Phone # _____ Cell # _____

Address _____ City _____State _____ Zip _____

Employer _____ Occupation _____Work # _____

Orthodontic Insurance Information

Subscriber _____ SS#_____ Birthdate _____

Insurance Co. _____ Group # _____ Employer_____

Insurance Co. Phone _____ Address _____

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Subscriber _____ SS#_____ Birthdate _____

Insurance Co. _____ Group # _____ Employer_____

Insurance Co. Phone _____ Address _____

To the best of my knowledge, all of the preceding answers are true and correct. If my health changes, or if my medicines change, I will inform the office as soon as possible.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover

Signature of Patient/Responsible Party _____