Patient Name: ______________________

Patient Information Sheet

First Appointment: ______________________

Nickname: ______________________ Email Address: ______________________

Patients Address: ______________________ Telephone: ____________

Birthdate: ____________ Age: ______ Yr ______ Mo Sex: M / F Cell Phone : ____________

School: ______________________ Grade/Position: ____________

Interest/Sports ______________________

Names and Ages of Brothers & Sisters: ______________________

Primary Responsible Party: € Mother € Father € Step Parent € Self € Other (specify) ____________

______________________ Cell Phone: ____________

Address: ______________________ How long at this address? ______

Employer: ____________ Occupation: ____________ Work Phone: ____________

SSN or Insurance ID ______________________ How long employed? ____________

Secondary Responsible Party: € Mother € Father € Step Parent € Self € Other (specify) ____________

______________________ Cell Phone: ____________

Address: ______________________ How long at this address? ______

Employer: ____________ Occupation: ____________ Work Phone: ____________

SSN or Insurance ID ______________________ How long employed? ____________

How Did You Hear About Us? € Dentist € Patient € Relative € Acquaintance € Other ____________

Whom May We Thank For Referring You To Us? ______________________ Dentist: ____________

What is your main concern? ______________________

Circle Yes or No for which the patient has a history:

Aids/HIV	Y N	Emotional Problems	Y N	Immune Disorder	Y N	Rheumatic Fever	Y N
Allergies	Y N	Epilepsy/ Seizures	Y N	Low Blood Pressure	Y N	Speech problems	Y N
Asthma	Y N	Fainting, Dizziness	Y N	Mouth Breathing	Y N	TMJ problems	Y N
Bone Disorders	Y N	Glaucoma	Y N	Nervous Disorders	Y N	Pre-medication needed	Y N
Bulimia	Y N	Gums Bleed	Y N	Ortho Treatment	Y N	Tooth Grinding	Y N
Clicking of jaw	Y N	Headaches	Y N	Painful Chewing	Y N	Tonsils Removed	Y N
Cold Sores	Y N	Heart condition	Y N	Periodontal problems	Y N	Tuberculosis	Y N
Diabetes	Y N	Hepatitis	Y N	Pregnant	Y N	Wisdom Tooth Extractions	Y N
Drug Allergies	Y N	High Blood Pressure	Y N	Prolonged Bleeding	Y N		

Any disease, problems, or allergies not mentioned above? ______________________

Current Medications? ______________________

Any face, mouth or teeth injuries? ______________________

Has an orthodontist been consulted previously? Y N If yes, please specify ______________________

Insurance Information *(Please fill out completely so we may properly file your insurance)*

Name of Primary Orthodontic Insurance: ______________________ Telephone: ____________

Name of Policy Holder: ______________________ € Mother € Father € Step Parent € Self € Other ______

Policy Holders Birthdate: ______________________ SSN or Insurace ID ____________

Name of Secondary Orthodontic Insurance: ______________________ Telephone: ____________

Name of Policy Holder: ______________________ € Mother € Father € Step Parent € Self € Other ______

Policy Holders Birthdate: ______________________ SSN or Insurace ID ____________

Signature: ______________________ Relationship To Patient: ____________ Date: ____________