

# WELCOME

We would like to welcome you to our office. In an effort to provide the best service possible, we ask you to fill out this form as completely as possible. Thank you for your cooperation.

## Patient Information

Name \_\_\_\_\_  
Last First Middle Sex Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_

Who may we thank for referring you to our office \_\_\_\_\_

## Spouse / Additional Contact Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Are you under the care of a physician?  Yes  No If Yes, explain \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Address \_\_\_\_\_

Are you pregnant  Yes  No If so how many weeks \_\_\_\_\_

What are the main concerns that you would like orthodontics to accomplish? \_\_\_\_\_

Have you ever been evaluated for orthodontic treatment? \_\_\_\_\_

Have you tonsils or adenoids been removed?  Yes  No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)?  Yes  No

Do you have any missing or extra permanent teeth?  Yes  No

Have you ever had an injury to : (select all that apply)  Teeth  Mouth  Chin

Do you have speech problems?  Yes  No if Yes, explain \_\_\_\_\_

Do your gums bleed?  Yes  No Do you smoke?  Yes  No Do you like your smile?  Yes  No

Does/Have you ever had any of the following habits?

- Lip Sucking/Biting  Nail biting  Prolonged Bottle/Pacifier  
 Clenching/Grinding Teeth  Mouth Breather  Tongue Thrusting  Thumb/ Finger Sucking

Are you allergic to any of the following?

- Aspirin  Erythromycin  
 Codeine  Penicillin  
 Tetracycline  Latex  
 Any Metals/Plastics

Other Allergies/Sensitivites:

\_\_\_\_\_

List all drugs you are currently taking

\_\_\_\_\_

List any serious medical condition(s) treated

\_\_\_\_\_

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filing out this form \_\_\_\_\_ Date \_\_\_\_\_