Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

Email Address_____General Dentist_____

Responsible Party Information

Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Do you own or rent?_____ Email Address_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Other Responsible Party Name_____ _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Home Phone_____ Work Phone_____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Do you own or rent?_____ Email Address_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____Occupation_____No. Years Employed_____

Insurance Information

Insured's Name_____Birthdate_____Soc. Sec. #_____

Insurance Company_____Group No._____ Local No._____

Insurance Co. Address_____

Do you have dual coverage? Yes ☐ No ☐ If yes: Insured's Employer_____

Insured's Name_____Birthdate_____Soc. Sec. #_____

Insurance Company_____Group No._____ Local No._____

Insurance Co. Address_____

I understand that when appropriate, a "soft credit check"* may be obtained to assist us in granting you our 0% in-house financing.
*If needed, ask Front Desk personnel for more information.

Signature _____ Date_____

Kevin J. Andrews D.D.S., M.S.
2125 Green Vista Dr. Suite 104
Sparks, NV 89431
775-674-1444

Date_____

Patient's Name_____ Age_____ Birthdate_____

Whom may we thank for referring you to our office?_____

Hobbies/Interests_____

Medical History

YES NO

____ ____ Is patient presently under a physician's care?

For_____

____ ____ Is patient taking any pills, medications, or drugs?_____

_____

____ ____ Has patient ever had an unusual reaction to medication?_____

_____

____ ____ Is patient allergic to anything?_____

_____

____ ____ Has patient had any major surgery? For_____

_____

____ ____ Does patient have a chronic problem with ☐ Kidney, ☐ Heart, ☐ Lung, ☐ Liver.

____ ____ Are there any other medical problems not mentioned above?_____

Describe:_____

____ ____ Has patient been diagnosed or treated for any of the following:

☐ Diabetes ☐ Arthritis ☐ Bone ☐ Emotional ☐ Epilepsy ☐ Anemia

☐ Endocrine ☐ Asthma ☐ Fainting ☐ Cerebral palsy ☐ Prolonged bleeding

☐ Heart trouble ☐ Rheumatic fever ☐ Tonsils removed ☐ Adnoids removed

Dental History

YES NO

____ ____ Does patient now suck thumb or fingers?
____ ____ Does patient breathe predominantly through the mouth?
____ ____ Does the patient clench or grind teeth? ☐ at night ☐ during day
____ ____ Does the patient have pain or clicking upon closing the mouth?
____ ____ Has the patient had any severe head or face injuries? When_____
____ ____ Have any teeth been injured or chipped due to accidents? When_____
____ ____ Any noticeable difficulty in chewing or swallowing food?
____ ____ Has patient been informed of any extra or missing teeth?
____ ____ Have any teeth been removed by extraction? Why_____
____ ____ Has any member of the family had orthodontic treatment? Who_____
____ ____ Have you had any previous orthodontic consultation or treatment?
____ ____ Would patient mind wearing ☐ Bands? ☐ Headgear?
Month of last dental appointment_____