Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Cell 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

Cell Phone_____ Work Phone_____ Home Phone_____

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

Cell Phone_____ Work Phone_____ Home Phone_____

Email Address_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer _____Occupation _____ No. Years Employed_____

DENTAL Insurance Information

Who is Insurance Policy Under (Self, Parent, Etc?)Name: _____

Policy Holder's Birthdate_____ Policy Holder's Soc. Sec. #_____

Name of Insurance Company (ie: Blue Cross) _____

Group No._____ Policy or Member ID# on Card: _____

Employer (Job) _____

Address of Policy Holder _____

Insurance Co. Customer Service Phone # on Back of Card: _____

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

Insured's Name_____Birthdate_____Soc. Sec. #_____

Insurance Company_____ Group No._____

Insurance Co. Customer Service Phone #_____

Date_____

Patient's Name_____ Age_____ Birthdate_____ Sex_____

Grade_____ School_____ Names of brothers and sisters_____

Plays musical instrument ☐ Yes ☐ No Type of musical instrument_____

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

Previous speech therapy? ☐ Yes ☐ No Hobbies/Interests_____

YES NO **Medical History**

____ ____ 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: (Circle)

Diabetes Arthritis Bone Recession Osteoporosis Epilepsy Anemia

Endocrine Asthma Fainting Cerebral palsy Prolonged bleeding

Heart trouble Rheumatic fever Tonsils removed Adenoids removed

YES NO **Dental History**

____ ____ 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 (baby or permanent) 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?
____ ____ Has patient ever been teased about appearance of his/her teeth?
____ ____ Does the patient want his/her teeth straightened?
____ ____ Has a dentist ever placed a retainer or space maintainer? Month of last dental appointment_____