



Patient Information

Patient Name: _____ Gender: M / F
(Mr. Mrs. Ms.) First Last

Street: _____ City: _____ Prov.: _____ PC: _____
Postal Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Health Card #: _____ Birth date: _____ Age: _____ Email: _____

School/Employer: _____ Spouse: _____

Other immediate family members seen by us: _____

Whom may we thank for referring you to our office? Dentist Friend Family Member Website Other: _____

Dentist: _____ Family Doctor: _____

Names & ages of siblings: _____

Patient's hobbies & interest: _____

Parent/Guardian Information (Please complete if patient is under the age of 18)

Patient lives with: Both Parents Mother Father Shared between Mother & Father Other: _____

Parent's Marital Status: Married Divorced Partnered Separated Single Widowed

Mother Stepmother Guardian

Father Stepfather Guardian

Name: _____ Name: _____

Address: _____ Address: _____

(If different from patient) (If different from patient)

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Person responsible for the account: _____ Relationship to patient: _____
(Mr. Mrs. Ms.) First Last

Patient Insurance Information
*Our office charges the patient/parent/guardian directly for all professional services rendered.
We will complete the necessary forms so that you can receive the reimbursement to which you are entitled under your policy.*

Do you have orthodontic coverage? Yes No Unsure

Primary Insurance

Group/Plan #: _____

ID #: _____

Subscriber's Name: _____

Subscriber's Birthday: _____ MM / DD / YY

Employer: _____

Insurance Company: _____

Secondary Insurance

Group/Plan #: _____

ID #: _____

Subscriber's Name: _____

Subscriber's Birthday: _____ MM / DD / YY

Employer: _____

Insurance Company: _____

Patient's Dental History

Reason for orthodontic consultation (patient concern): _____

Have you ever been evaluated for orthodontic treatment? Yes No

Have you ever had orthodontic treatment? Yes No

If yes, please specify name of orthodontist: _____

Has anyone else in the family had a similar orthodontic problem? Yes No

When was your last visit to the dentist? _____

Has a Panoraphic x-ray been taken recently? Yes No

Have you been informed of any missing permanent teeth? Yes No

Have you been informed of any extra teeth? Yes No

Have any teeth been removed by the dentist? Yes No

Have there been any injuries to the face, mouth, teeth or chin? Yes No

If yes, please specify: _____

Do you presently have, or have you ever had any of the following habits?

Thumb/finger sucking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lip/nail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tongue thrusting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clenching/grinding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you presently have, or have you ever had any of the following?

Tonsils removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adenoids removed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chewing/eating problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent earaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No

Clicking/locking/discomfort in jaw joints near ears Yes No

Patient's Medical History

Are you in good health? Yes No

Do you presently have, or ever had any of the following?

Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints/bones/valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fetal Alcohol Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Growth problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone disorders/bone loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital heart defect	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Canker sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic/Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemo/radiation therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers/Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emotional problems/anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Environmental allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If yes to any of the above, please explain: _____

Describe any other medical condition not listed: _____

Does the patient require antibiotics for dental treatment? Yes No

If yes, please explain: _____

List any other allergies or drug sensitivities: _____

List any drugs or medication now being taken: _____

Any serious illnesses or recent hospitalizations? _____

Patient/Parent/Guardian Signature: _____ Date: _____

(Parent/Guardian please sign if child is under 18 years of age)