

PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date
Patient's name Last First Middle
Address Street City Zip
Nickname Birth date
School Grade Sports/Hobbies/Interests
Parent or guardian name
Whom may we thank for referring you to our office?

RESPONSIBLE PARTY INFORMATION

Name Last First Middle
Residence Street City Zip
Mailing Address Street City Zip
Home phone Cell/other phone Work phone
Email address
Parents' marital status
Social Security # Birth date Relationship to Patient
Employer Occupation No. years employed
Spouse's Name Relationship to Patient
Employer Occupation No. years employed
Social Security # Birth date Work Phone

DENTAL INSURANCE INFORMATION

Insured Name Insured Social Security #
Insurance Company Group No. Local No.
Insurance Co. Address Phone No.
Do you have dual coverage? Yes No If yes:
Insured's Name Insured's Social Security #
Insurance Company Group No. Local No.
Insurance Co. Address Phone No.

EMERGENCY INFORMATION

Name of nearest relative not living with you
Complete address Street City Zip
Home phone Cell/other phone
I understand that, where appropriate, credit bureau reports may be obtained.
Responsible Party Signature
Updates (date & initial)

## MEDICAL HISTORY

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? \_\_\_\_\_  
Yes No Is the patient allergic to any medication, metals, plastic or latex? \_\_\_\_\_  
Yes No History of a major illness? \_\_\_\_\_  
Yes No Has the patient had any operations? \_\_\_\_\_  
Yes No Ever been involved in a serious accident? \_\_\_\_\_  
Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_

### Female Patients only (used to determine the amount of growth remaining):

Yes No Has menstruation started, and if so, month/year? \_\_\_\_\_  
Yes No Is the patient pregnant? \_\_\_\_\_

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay fever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous or Psychiatric Disorder	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

## DENTAL HISTORY

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_

Did your dentist refer you to our office? YES or NO (circle response)

What concerns you most about your teeth or smile? \_\_\_\_\_

Yes No Is the patient presently in any dental pain? \_\_\_\_\_  
Yes No Ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_  
Yes No Has the patient ever lost or chipped any teeth? \_\_\_\_\_  
Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_  
Yes No Do gums bleed when brushing? \_\_\_\_\_  
Yes No Any type of thumb or tongue habit? \_\_\_\_\_  
Yes No Is the patient a mouth breather? \_\_\_\_\_  
Yes No Has the patient ever seen an orthodontist? If yes, who and when? \_\_\_\_\_  
Yes No Has anyone in the family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_  
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? \_\_\_\_\_  
Yes No Experience jaw clicking or popping? \_\_\_\_\_  
Yes No Aware of clenching or grinding teeth during the day? \_\_\_\_\_  
Yes No Experience "tension" headaches? \_\_\_\_\_  
Yes No Does the patient need extra help with instructions? \_\_\_\_\_  
Yes No Is the patient sensitive or self-conscious about his/her teeth? \_\_\_\_\_  
What is the patient's attitude toward receiving orthodontic treatment? \_\_\_\_\_  
Height of parents: Mom \_\_\_\_\_ Dad \_\_\_\_\_

## BENEFITS

Benefits of Orthodontics: Aesthetics, Health, and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. I understand that the information that I have given here is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical and/or dental status. I authorize the dental/orthodontic staff to perform any necessary dental/orthodontic services and procedures that I may need during diagnosis and treatment, with my informed consent. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services. I have read and understand this paragraph. In addition, I authorize Dr. Tsibel to perform a complete orthodontic evaluation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_