PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE

Date: _____

Patient's name: _____
Last First Middle

Address: _____
Street City Zip

Nickname: _____ Birthdate: _____ Social Security #_____
School: _____ Sports/Hobbies: _____
Parent or guardian name: _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Parent's Marital Status: Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Remarried ( ) Single ( )

Guardian #1 ( ) Step Parent ( ) Name: _____ Birthdate: _____
Social Security #: _____ Home #: _____ Work #: _____ Cell #: _____
Email: _____ Address: _____
Employer: _____ Occupation: _____

Guardian #2 ( ) Step Parent ( ) Name: _____ Birthdate: _____
Social Security #: _____ Home #: _____ Work #: _____ Cell #: _____
Email: _____ Address: _____
Employer: _____ Occupation: _____

PRIMARY INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Security # _____
Insurance Company: _____ Group No._____ Local No._____
Insurance Co. Address: _____ Phone No. _____

SECONDARY INSURANCE INFORMATION

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: _____ Phone # _____

I understand that, where appropriate, credit bureau reports may be obtained.
Parent 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? _____
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:
Yes No Has menstruation started? If yes, appox. date: _____
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 Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions/special needs we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

General Dentist _____ Date of last visit _____
What concerns you most about your teeth? _____

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 Is any part of your mouth sensitive to temperature? Where? _____
Yes No Is any part of your mouth sensitive to pressure? Where? _____
Yes No Do gums bleed when brushing? _____
Yes No Any type of finger 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 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 (or night)? _____
Yes No Experience “tension” headaches? _____
Yes No Does the patient need extra help with instructions? _____
Yes No Are you aware that some appointments will be during school hours?

AUTHORIZATION

I attest that I have answered all the above questions truthfully and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Tsibel to perform a complete orthodontic evaluation.

Signature: _____ Date: _____