

PATIENT INFORMATION

Date _____ Patient's Name _____
Last First MI

Address _____
Street City Zip

Birth date _____ Social Security # _____ Best Phone _____

If patient is a minor, give parent's or guardian's name _____

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

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____
Last First Middle Initial

Address _____
Street City Zip

Cell/Other Phone _____ Text Y N Home Phone # _____ Work Phone # _____

Email Address _____ Social Security # _____ Birth date _____

Employer _____ Occupation _____ Years Employed _____

Spouse or Other Billing Party _____ Relationship to Patient _____
Last First MI

Address _____
Street City Zip

Cell/Other Phone _____ Text Y N Home Phone # _____ Work Phone # _____

Email Address _____ Social Security # _____ Birth date _____

Employer _____ Occupation _____ Years Employed _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____ Phone # _____

Do you have Dual Coverage? Yes ___ No ___ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group # _____ Local # _____

Insurance Company Address _____ Phone # _____

EMERGENCY CONTACT INFORMATION

Name of nearest relative not living with you _____ Phone # _____

Complete Address: _____
Street City Zip

I understand that, where appropriate, credit bureau reports may be obtained.

Signature (Patient or Parent/Guardian's signature if minor) _____

Updates (date & initial) _____

MEDICAL HISTORY

Patient Name _____ Today's Date _____

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle YES or NO (If YES, please fill in details)

YES NO Are you taking any medication? _____
YES NO Are you allergic to any medications? _____
YES NO Do you have any history of major illness? _____
YES NO Have you had any operations? _____
YES NO Have you ever been involved in a serious accident? _____
YES NO Have you seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have:

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

What concerns you most about your teeth? _____

YES NO Are you presently in any dental pain? _____
YES NO Have you ever experienced any unfavorable reaction to dentistry? _____
YES NO Have you ever lost or chipped any teeth? _____
YES NO Have there been any injuries to the face, mouth or teeth? _____
YES NO Is there any part of your mouth sensitive to temperature? Where? _____
YES NO Is there any part of your mouth sensitive to pressure? Where? _____
YES NO Do your gums bleed when you brush? _____
YES NO Do you have any type of thumb or tongue habit? _____
YES NO Are you a mouth breather? _____
YES NO Have you ever seen an Orthodontist? If yes, who and when? _____
YES NO What is your attitude toward receiving orthodontic treatment? _____
YES NO Has anyone in your family received orthodontic treatment? _____
How did they feel about the results? _____
YES NO Do your teeth or jaws ever feel uncomfortable when you wake in the morning? _____
YES NO Are you aware of your jaw clicking or popping? _____
YES NO Are you aware of clenching your teeth during the day? _____
YES NO Do you have "tension" headaches? _____
YES NO Have you ever experienced chronic ringing in your ears? _____
YES NO If the patient is under 16, height of parents? Mom _____ Dad _____
YES NO Are you aware that some appointments will be during school/work hours? _____

Female Patients Only

YES NO Are you pregnant? _____
YES NO Has menstruation started? _____

BENEFITS

Benefits of Orthodontics: Aesthetics, Health and Function. Orthodontics is a service that provides an improvement in the appearance of teeth, in the general function of teeth, and in general dental health. Teeth, gums, and jaws are an intricate body part and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums can result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of the teeth and some change after treatment. I have read and understand this paragraph. I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all of the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize Dr. Jackson to perform a complete orthodontic evaluation.

Signature _____ Date _____