ORTHODONTIC
CARE CENTER

1. ABOUT YOU

DATE _____

Name_____ I prefer to be called_____ ○ Male ○ Female

Email address_____ Birth date_____ Social Security _____

Home Address _____

City _____ State_____ Zip_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #_____ Work#_____ Cell#_____

Employer_____ How long there?_____ Occupation_____

Other family members seen by us?_____

Who may we thank for referring you?_____

General Dentist:_____ Date of last visit:_____

2. SPOUSE INFORMATION

Name_____ Birth date_____ Social Security _____

Employer_____ How long there?_____ Occupation_____

3. INSURANCE INFORMATION

PRIMARY

Insured's Name_____ Insured's SS#_____

Relationship to patient_____

Insurance Company_____ Group #_____ Phone_____

Insured's Employer_____ Insured's Date of Birth_____

Address of Insured_____ City_____ State_____ Zip_____

SECONDARY

Insured's Name_____ Insured's SS#_____

Relationship to patient_____

Insurance Company_____ Group #_____ Phone_____

Insured's Employer_____ Insured's Date of Birth_____

In the event of an emergency is there someone who lives near you that we should contact?

Name_____ Relationship to patient_____ Phone _____

ORTHODONTIC
CARE CENTER

4. MEDICAL HISTORY

Are you currently under the care of a physician? ◯ Yes ◯ No Please explain:_____

Physician's Name_____ Phone #:_____ Date of Last Visit:_____

Are you currently taking any medication? Please list each one:_____

Are you allergic to: ☐ Latex ☐ Plastics / Metals ☐ Aspirin ☐ Penicillin ☐ Other_____

For Women: Are you pregnant? ◯ Yes ◯ No If yes, weeks_____ Are you nursing? ◯ Yes ◯ No

Have you ever had any of the following medical conditions?

Y N Abnormal Bleeding	Y N Epilepsy / Seizures / Fainting	Y N Psychiatric Problems
Y N Anemia	Y N Fever Blisters / Herpes	Y N Rheumatic / Scarlet Fever
Y N Artificial Bones / Joints / Valves	Y N Glaucoma	Y N Severe / Frequent Headaches
Y N Asthma / Arthritis	Y N Heart Condition	Y N Shingles
Y N Blood Transfusion	Y N Hepatitis	Y N Sickle Cell Disease
Y N Cancer / Chemotherapy	Y N High / Low Blood Pressure	Y N Sinus Problems / Difficulty Breathing
Y N Congenital Heart Defect	Y N HIV+ / AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Ulcers
Y N Drug / Alcohol Abuse	Y N Mitral Valve Prolapse	Y N Venereal Disease
Y N Emphysema		

5. DENTAL HISTORY

What treatment goals would you like to accomplish? _____

Have you ever been evaluated by an orthodontist before? ◯ Yes ◯ No

Have you ever experienced TMJ pain? ◯ Yes ◯ No

Have you been informed of missing or extra teeth? ◯ Yes ◯ No

Have you had injury to your mouth, chin or teeth? ◯ Yes ◯ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Have you ever taken Fosamax or any other bisphosphonate? ◯ Yes ◯ No

Have you ever taken Phen-Fen? ◯ Yes ◯ No

Do you generally breathe through your mouth? If yes, please circle: While Awake? While Asleep?

I understand that the information given is correct to the best of my knowledge.
I also understand that where appropriate, a credit report may be obtained.

Signature_____ Date_____