Patient Information Sheet
Please Bring in With You

First Name: ☐ Last Name: ☐

First Appointment:

Nickname: ______ Email:

Patients Address: ______ Zip: ______ Telephone: ______

Birthdate: ______ Age: ______ Sex: ______

School/Employer: ______ Grade/Position: ______

Interest/Sports ______

Primary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Responsible Party: ______ DOB: ______

Address: ______ Zip: ______ Telephone: ______

Employer/Address: ______ Telephone: ______

Social Security Number: ______ Primary Party Email Address: ______

Secondary

☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Responsible Party: ______ DOB:: ______

Address: ______ Zip: ______ Telephone ______

Employer/Address: ______ Telephone: ______

Social Security Number: ______ Secondary Party Email Address: ______

How Did You Hear About Us? ☐ Dentist ☐ Patient ☐ Relative ☐ Acquaintance ☐ Other ______

Whom May We Thank For Referring You To Us? ______ Present Dentist: ______

Reason For Consultation: ______

Circle Yes or No for which the patient has a history:

Condition	Y N	Condition	Y N	Condition	Y N	Condition	Y N	Condition	Y N	Condition	Y N
ADD/ADHD	☐Y N☐	Bulimia	☐Y N☐	Downs Syndrome	☐Y N☐	Hepatitis	☐Y N☐	Painful chewing	☐Y N☐	Smoking/Tobacco	☐Y N☐
Aids	☐Y N☐	Cancer	☐Y N☐	Drug allergies	☐Y N☐	High Blood Pressure	☐Y N☐	Periodontal problems	☐Y N☐	Speech problems	☐Y N☐
Allergies	☐Y N☐	Cerebral palsy	☐Y N☐	Endocrine problems	☐Y N☐	Immune problems	☐Y N☐	Pneumonia	☐Y N☐	TMJ problems	☐Y N☐
Anemia	☐Y N☐	Chest pains	☐Y N☐	Emotional disorders	☐Y N☐	Kidney problems	☐Y N☐	Pregnant	☐Y N☐	Tooth Grinding	☐Y N☐
Arthritis	☐Y N☐	Chronic neck pain	☐Y N☐	Epilepsy	☐Y N☐	Low Blood Pressure	☐Y N☐	Prolonged Bleeding	☐Y N☐	Tuberculosis	☐Y N☐
Aspirin	☐Y N☐	Clicking of jaw	☐Y N☐	Fainting, Dizziness	☐Y N☐	Mouth breathing	☐Y N☐	Rheumatic Fever	☐Y N☐	Venereal Disease	☐Y N☐
Asthma	☐Y N☐	Cold Sores/Herpes	☐Y N☐	Glaucoma	☐Y N☐	Muscular disorders	☐Y N☐	Scoliosis	☐Y N☐	Sinusitis	☐Y N☐
Autoimmune	☐Y N☐	Diabetes	☐Y N☐	Headaches	☐Y N☐	Nervous Disorders	☐Y N☐	Seizures	☐Y N☐	Prosthetic Joints	☐Y N☐
Bone Disorders	☐Y N☐	Diet pill usage	☐Y N☐	Heart condition	☐Y N☐	Organ Transplant	☐Y N☐	Sicca	☐Y N☐	Bone Medication	☐Y N☐

Any disease, problems, or allergies not mentioned above? ______

Current Medications? ______

Females: Have you started Menstruating? ______ At what age? ______

Have wisdom teeth been extracted? ______ Any face, mouth or teeth injuries? ______

Does the patient normally breathe through the mouth while awake or asleep? ______ Do gums bleed when brushed or flossed? ______

When was your last dental cleaning and check up? ______ Have you had previous orthodontic treatment? ______

Are there any missing or extra teeth? ______ Have the Tonsils and adenoids been removed? ______

Any oral habits such as thumb-sucking or nail-biting? ______

Names and Ages of Brothers & Sisters: ______

Insurance Information *(Please fill out completely so we* may properly file your insurance)

Name of Primary Orthodontic Insurance: ______ Telephone: ______

Name of Policy Holder: ______ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Policy Holders Birthdate: ______

Name of Secondary Orthodontic Insurance: ______ Telephone: ______

Name of Policy Holder: ______ ☐ Mother ☐ Father ☐ Step Parent ☐ Self ☐ Other (specify) ______

Policy Holders Birthdate: ______

Signature: ______ Relationship To Patient: ______ Date: ______