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:

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: _____