Please complete if patient is a minor:

Parent's or Guardian's Name____________________

Address____________________

Mobile phone number (typically best for confirming appointments)____________Work phone number____________

Home phone number ____________ E-Mail Address____________

Father Employed by____________No. of years______ Position____________

Mother Employed by____________ No. of years______ Position____________

Do you have orthodontic insurance benefits? YES NO

Who will be financially responsible for the orthodontic treatment? ____________

If divorce is involved, who is the custodial parent? ________ May patient information be released to the non-custodial parent? ______

Patient's Name____________ Birth Date____________

School (if student) ____________Grade____________

Names and ages of siblings____________

Please complete if patient is an adult:

Patient's Name____________ Birth Date____________

Address____________________

Mobile phone number (typically best for confirming appointments)____________Work phone number____________

Home phone number ____________ E-Mail Address____________

Employed by____________ No. of years______ Position____________

Do you have orthodontic insurance benefits? YES NO

MEDICAL HISTORY

YES	NO		
☐	☐	1)	Are you now under a physician's care? For what reason?
☐	☐	2)	Do you pre-medicate with antibiotics for dental visits?
☐	☐	3)	Are you currently taking any medications? What?
☐	☐	4)	Have you ever been diagnosed with osteoporosis, osteopenia, or bone cancer? If so, what medications have been taken?
☐	☐	5)	Allergies: latex, food, pollen, drugs, metals, plastics, etc.
☐	☐	6)	Any congenital or acquired physical or mental disabilities? What
☐	☐	7)	Review of systems – any problems with: head, eyes, ears, nose, throat, heart, lungs, stomach-gut, glands/endocrine, bones, skin, nerves, personality
☐	☐	8)	Illnesses (circle): rheumatic fever, mumps, measles, chicken pox, diphtheria, scarlet fever, blood pressure/heart disease, herpes, tonsillitis, hepatitis, VD, HIV/AIDS, influenza, cancer, diabetes, blood problems, TB, epilepsy, rubella.
☐	☐	9)	Any history of chronic headaches or pain around ears
☐	☐	10)	Any problems with nasal breathing or tonsils and adenoids?
☐	☐	11)	Any other information?

The information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental staff to perform any necessary dental services that I or my child may need during diagnosis and treatment with my informed consent. I have also received a copy of the office's notice of privacy practices.

Signature____________________ Date ________