Patient Information

Date:

Patient Name:

First Last Middle

Address:

Street Apt # City Zip

Email Address:

Cell Phone: Social Security #:

Date of Birth: If patient is a monor, what school do they attend?:

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

Whom may we thank for referring you to our office?

Responsible Party Information

Relationship to patient:

Name:

First Last Middle

Address:

Street Apt # City Zip

Cell Phone: Work Phone:

Date of Birth: Social Security #:

Other parent's or guardian's name:

Their relationship to patient:

Phone:

Dental Insurance Information

Insured's Name: Insured's Social Security #:

Insurance Company: Phone #:

Insurance Company Address:

Group #: Member #:

Do you have Dual Coverage? Yes No If Yes:

Insured's Name: Insured's Social Security #:

Insurance Company: Phone #:

Insurance Company Address:

Group #: Member #:

Emergency Information

Name:

First Last

Address:

Street Apt # City Zip

Phone #:

Medical History

Physician 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 medication or Latex?

Yes No Do you have a history of a major illness?

Yes	No	Have you had any operations?
Yes	No	Have you ever been involved in a serious accident?

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

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

Dental History

General Dentist: Last Visit:

What concerns you most about your teeth?

Yes	No	Are you presently in dental pain?
Yes	No	Have you experienced any unfavorable reaction to dentistry?
Yes	No	Have you ever lost or chipped any teeth?
Yes	No	Have there been any injuries to face, nouth or teeth?
Yes	No	Is any part of your mouth sensitive to temperature? Where?
Yes	No	Is any part of your mouth sensitive to pressure? Where?
Yes	No	What is your attitude towards receiving orthodontic treatment?
Yes	No	Has anyone in your family received orthodontic treatment?
Yes	No	Do your teeth or jaws ever feel uncomfortable when you awake in the morning?
Yes	No	Are you aware of your jaw clicking or popping?
Yes	No	Are you aware of clenching your teeth?
Yes	No	Have you ever been told that you grind your teeth?
Yes	No	Have you ever experienced chronic ringing in your ears?
Yes	No	Are you aware that some appointments will be during school/work hours?
Yes	No	Are you pregnant?
Yes	No	Has menstruation started?

If the patient is under age 16, What are the height of parents? Mom Dad

Benefits

Benefits of orthodontics: Aesthetic, Health and Function. Orthodontics is a service that provides an improvement in the appearance of the teeth, in general function of the 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 teeth and some change after treatment. I have read and understand this paragraph. I also understand that my or my childs diagnostic records and 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. Freeman to perform a complete orthodontic evaluation. I understand that, where appropriate, credit bureau report may be obtained.

Signature: Date: