## NEW PATIENT INFORMATION

Date: _____

Last name: _____ First name: _____

Home Address: _____ City: _____ State: ____ ZIP: _____

Sex: _____ Age: _____ DOB: _____ Contact Email: _____

Home PH: _____ Cell PH: _____ Work PH: _____
(Father □ Mother □ Self □)

Home PH: _____ Cell PH: _____ Work PH: _____
(Father □ Mother □ Spouse □)

If Patient is under 18 years of age, parental information is required

Mother's Name: _____ Father's Name: _____

Mother's Employer: _____ Father's Employer: _____

Mother's Occupation: _____ Father's Occupation: _____

Person(s) responsible for financial account and appointments: _____

## Orthodontic Insurance Information

Orthodontic Insurance: Father □ Mother □ Self □ Spouse □ Dual Coverage? Y □ N □

Insured's Name: _____ SSN: _____ DOB: _____

Insurance Company: _____ Group # _____

Insured's Name: _____ SSN: _____ DOB: _____

Insurance Company: _____ Group # _____

Dentist Last Name: _____ Dentist First Name: _____Date of Last Dental Exam: _____

Dentist Address: _____ Dentist PH: _____

Referred to our office by: _____

## MEDICAL HISTORY

Are you currently under a physician's care? Yes □ No □ If yes, why? _____

Please mark Y/N or DK (Don't Know):

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| _____ | Asthma | _____ | Bleeding Gums | _____ | Tonsils/Adenoids Removed | _____ | Mouth Breather |
| _____ | Diabetes | _____ | Prolonged Bleeding | _____ | Fainting/Dizziness | _____ | Eating Disorder |
| _____ | Epilepsy | _____ | Kidney Problems | _____ | HIV/AIDS Positive | _____ | Heart Trouble |
| _____ | Pregnant | _____ | Psychiatric Care | _____ | Hepatitis/Liver problems | _____ | Bone Disorder |
| _____ | Nursing | _____ | Difficulty Opening Mouth | _____ | Glandular Problems | _____ | Eating Disorder |
| _____ | Tobacco Use | _____ | Pain Upon Chewing | _____ | High/Low Blood Pressure | _____ | Latex Allergy |

*Have you/your child ever taken oral or intravenous bisphosphonates?: Yes □ or No □ Dates: _____

List any significant illness not mentioned above: _____

Allergies: _____

List any drugs or medications now being taken: _____

## DENTAL HISTORY

| | | |
|---|---|---|
| Has the patient ever sucked a thumb or finger? Until what age? _____ | Y □ | N □ |
| Does the patient have any missing permanent teeth? | Y □ | N □ |
| Have you been informed of any extra teeth? | Y □ | N □ |
| Have any teeth been injured due to an accident or fall? | Y □ | N □ |
| Is the patient especially apprehensive about this visit? | Y □ | N □ |
| Have you had any previous orthodontic consultation or treatment? | Y □ | N □ |

Briefly state your chief concern: _____

Patient Signature (or Parent if minor): _____

**FOR OFFICE USE ONLY**

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Overbite: ____ Frenum: Y □ N □ Diastema: ____ Hyg: _____ Profile: _____ P: ____ M: _____ D: _____

Overjet: _____ Crowding: _____ TMJ: _____

Oral Habits: _____ Oral Cancer: _____ Perio: _____

Chief Complaint: _____

Other Findings: _____

_____

_____

Summary: _____

_____

_____

Recommendations: _____

_____

Exam Fee: _____ Consult Fee: _____ PAN: _____ Photo: _____ HF: _____ Other: _____

Models Appt.: _____ Consult Appt.: _____ Approx. Fees: _____

Notes: _____

_____

_____

_____

_____

NP Letter: _____