

		ACCOUNT NO.	MODEL NO.	NAME	
NAME			DATE OF INITIAL CALL	PERSON CALLING / RELATION TO PATIENT	
REFERRED BY			GENERAL DENTIST		
CHIEF COMPLAINT: REASON FOR SEEKING ORTHODONTIC EVALUATION					
					SCHOOL ATTENDED
BIRTHDATE	AGE (of a minor)	SEX	MARITAL STATUS U S M W D	OTHER FAMILY MEMBERS TREATED BY DOCTOR	SIBLINGS - AGES
MOTHER (of a minor)			FATHER (of a minor)		
PATIENT'S ADDRESS			CITY	STATE	ZIP
HOME PHONE	DAY PHONE	WHO WILL ACCOMPANY CHILD TO APPOINTMENT		INITIAL EXAM DATE	INITIAL EXAM TIME
NOTES					
DIAGNOSIS				HEALTH NOTES	
TREATMENT PLAN					
TREATMENT AGREEMENT			AGREEMENT DATE	AMORTIZATION PERIOD	

MEDICAL HISTORY

<p>IS PATIENT IN GOOD HEALTH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DOES THE PATIENT HAVE ANY HISTORY OF MAJOR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HAS THE PATIENT EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PLEASE LIST _____</p> <p>_____</p> <p>TENDENCY TO <input type="checkbox"/> COLDS <input type="checkbox"/> SORE THROATS <input type="checkbox"/> EAR INFECTIONS</p> <p>TONSILS OR ADENOIDS REMOVED? <input type="checkbox"/> YES <input type="checkbox"/> NO WHAT AGE? _____</p> <p>DRUGS OR MEDICATIONS NOW BEING TAKEN. GIVE REASON.</p> <p>_____</p> <p>_____</p> <p>ALLERGIES OR DRUG SENSITIVITY</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;">CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> INFECTIONS</td> <td><input type="checkbox"/> SOFT TISSUE LESIONS</td> </tr> <tr> <td><input type="checkbox"/> DIABETES</td> <td><input type="checkbox"/> ASTHMA</td> </tr> <tr> <td><input type="checkbox"/> PNEUMONIA</td> <td><input type="checkbox"/> KIDNEY INVOLVEMENT</td> </tr> <tr> <td><input type="checkbox"/> HEART TROUBLE</td> <td><input type="checkbox"/> ENDOCRINE PROBLEMS</td> </tr> <tr> <td><input type="checkbox"/> RHEUMATIC FEVER</td> <td><input type="checkbox"/> PROLONGED BLEEDING</td> </tr> <tr> <td><input type="checkbox"/> BONE DISORDERS</td> <td><input type="checkbox"/> FAINTING / DIZZINESS</td> </tr> <tr> <td><input type="checkbox"/> TUBERCULOSIS</td> <td><input type="checkbox"/> NERVOUS DISORDERS</td> </tr> <tr> <td><input type="checkbox"/> ANEMIA</td> <td><input type="checkbox"/> LIVER INVOLVEMENT</td> </tr> <tr> <td><input type="checkbox"/> EPILEPSY</td> <td><input type="checkbox"/> WEIGHT LOSS</td> </tr> <tr> <td><input type="checkbox"/> HEPATITIS</td> <td><input type="checkbox"/> LYMPH ADENOPATHY (SWOLLEN LYMPH GLANDS)</td> </tr> </table> <p>PATIENT'S PHYSICIANS:</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> INFECTIONS	<input type="checkbox"/> SOFT TISSUE LESIONS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ASTHMA	<input type="checkbox"/> PNEUMONIA	<input type="checkbox"/> KIDNEY INVOLVEMENT	<input type="checkbox"/> HEART TROUBLE	<input type="checkbox"/> ENDOCRINE PROBLEMS	<input type="checkbox"/> RHEUMATIC FEVER	<input type="checkbox"/> PROLONGED BLEEDING	<input type="checkbox"/> BONE DISORDERS	<input type="checkbox"/> FAINTING / DIZZINESS	<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> NERVOUS DISORDERS	<input type="checkbox"/> ANEMIA	<input type="checkbox"/> LIVER INVOLVEMENT	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> WEIGHT LOSS	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> LYMPH ADENOPATHY (SWOLLEN LYMPH GLANDS)
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DENTAL HISTORY

<p>INJURIES TO THE FACE, MOUTH OR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>SPEECH PROBLEMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>MISSING OR EXTRA PERMANENT TEETH <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HAS AN ORTHODONTIST BEEN CONSULTED PREVIOUSLY? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>PATIENT'S GENERAL DENTIST _____ PHONE _____</p> <p>PATIENT'S ORAL SURGEON (if one) _____ PHONE _____</p> <p>PATIENT'S PERIODONTIST (if one) _____ PHONE _____</p> <p>SIGNATURE OF RESPONSIBLE PATIENT, PARENT OR GUARDIAN _____ DATE _____</p>	<p>HAS THE PATIENT EVER SUCKED A THUMB OR FOREFINGERS? <input type="checkbox"/> YES <input type="checkbox"/> NO UNTL WHAT AGE? _____</p> <p>IS THE PATIENT A MOUTH BREATHER? <input type="checkbox"/> YES <input type="checkbox"/> NO WHILE AWAKE? _____ WHILE ASLEEP? _____</p> <p>MUSICAL INSTRUMENTS PLAYED: _____</p>
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EMERGENCY INFORMATION

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____	PHONE _____
COMPLETE ADDRESS _____	
PHONE _____	

PATIENT INFORMATION

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Parent's or guardian's name, if patient is a minor _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Relationship to Patient _____

Driver's License # _____ Birthdate _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

INSURANCE INFORMATION

Insured's Name _____ Insured Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Do you have dual coverage? Yes No If yes:

Insured's Name _____ Insured Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Company Address _____

Insured's Employer _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____

OFFICE USE ONLY	
Date	Initials