*A B C*

## PATIENT INFORMATION

**WELCOME TO OUR OFFICE!**

Date ______________

Patient's Name ______________________________________________
*Last* *First* *Middle*

Home Phone ______________________ Social Security # ______________________

School District ____________________ Grade ______ Height ______ Weight ______________

Have you been out of the country in last 2 years & where? ______________________________

Patient Physician ______________________ Patient: ______________________
*Email Address*

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## RESPONSIBLE PARTY INFORMATION

***(Person responsible for paying the account)***

Name ______________________________________________
*Last* *First* *Middle* *Marital Status*

Residence ______________________________________________
*Street* *City* *State* *Zip*

Mailing Address ______________________________________________
*Street* *City* *State* *Zip*

How long at this address __________ Responsible Party Email ______________________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Preferred appointment reminders (circle all that apply)? Home Phone / Work Phone / Cell Phone / Email Address

Previous Address (if less than 3 years) ______________________________
*Street* *City* *State* *Zip*

Social Security # ____________ Birth Date ____________ Relationship to Patient ____________

Employer ______________________ Occupation ____________ No. Years Employed ______

Spouse's Name ______________________________ Relationship to Patient ____________
*Last* *First* *Middle*

Spouse's Employer ______________________ Occupation ____________ No. Years Employed ______

Spouse's Social Security # ______________________ Spouse's Birth Date ______________

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## DENTAL INFORMATION

Date of last dental check-up ______________ Any facial or Dental injuries ______________

Please describe ______________________________________________

Any teeth removed by your dentist ______ Any thumb or finger sucking habit ______ If so, until age ______

Any difficulty breathing through the nose (awake or asleep) ______ Any tooth clenching and/or grinding ______

Any Speech problems __________ Any clicking or pain when opening or closing the mouth______________

## MEDICAL INFORMATION

Is the patient currently under the care of a physician _______ If so, why________________________________________

Is patient taking any medication now_________________ If so, what ________________________________________

Any allergies or drug sensitivity__________________ If so, what ____________________________________________

Have tonsils and/or adenoids been removed _________ If so, what age ________

Present or past medical problem ______________________________________________________________________

Please describe any present or hospitalization and operations _______________________________________________

Has the patient had blood transfusions ______ If so, please list date(s) and reason_______________________________

Have you ever taken Bisphosphonates?_________________________________________________________________

Present or past medical problem ______________________________________________________________________

Do you smoke or use tobacco?________________________ If so, for how long_________________________________

## GENERAL INFORMATION

What concerns you most about the patient's teeth and facial appearance? _____________________________________

Have other family members had orthodontic treatment?____________________________________________________

Has anyone in your family been seen in our office? _______ Name(s)_________________________________________

Does anyone in your family have a similar dental problem? __________________

Do you have siblings?___________ If so, please list names and dates of birth __________________________________

______________________________________________________________________________________________

## EMERGENCY INFORMATION

Preferred Emergency Contact Person ___________________________________________________________________

Complete Address _________________________________________________________________________________

Phone ________________________________________ Relationship to Patient _________________________________

Signature (Parent's signature, if minor) ___________________________________________ Date _____________________
I understand that where appropriate, credit bureau reports may be obtained.